

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13089

CERTIFICATE OF DEATH

13093

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt. 5 Marine Road</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE</u> First <u>Upshur</u> Middle <u>Adkins</u> Last		4. DATE OF DEATH <u>SEPTEMBER 11</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Plant</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cephus Adkins</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Pruitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-14-2785</u>	
17. INFORMANT Address <u>Mrs. Beatrice N. Adkins Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810 Hepatic Fibrosis</u> DUE TO (b) <u>Chronic pyelitis + stricture</u> DUE TO (c) <u>Conc. Heart Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Approx 1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pyelitis + stricture</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>67</u> to <u>9/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> , 19 <u>67</u> , and that death occurred at <u>12:50</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. Wallace</u>		22b. DATE SIGNED <u>11 Sept 67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Md.</u>
24. FUNERAL DIRECTOR <u>Thomas F. Wallace</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10/10/01

UNITED STATES DEPARTMENT OF JUSTICE

10/10/01

10/10/01

10/10/01



ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10-10-2001 BY 60322 UCBAW

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13050

13084

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>821 Camden Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>821 Camden Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>IRVING</u> Middle <u>-----</u> Last <u>BAKER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1967</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1898</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Isaac Baker</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Ropeka</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>War I</u>				16. SOCIAL SECURITY NO. <u>183-01-7274</u>				17. INFORMANT Name <u>Mrs. Lee K. Baker (Wife)</u> Address <u>821 Camden Ave., Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Salisbury, Maryland</u>							
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1967</u> to <u>9-18, 1967</u> that (I) (we) last saw the deceased alive on <u>9-16, 1967</u> and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>James R. Clifford M.D.</u>												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 18, 1967</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. James Clifford</u>												22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept. 19, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Beth Israel Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>							
24 FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>												25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

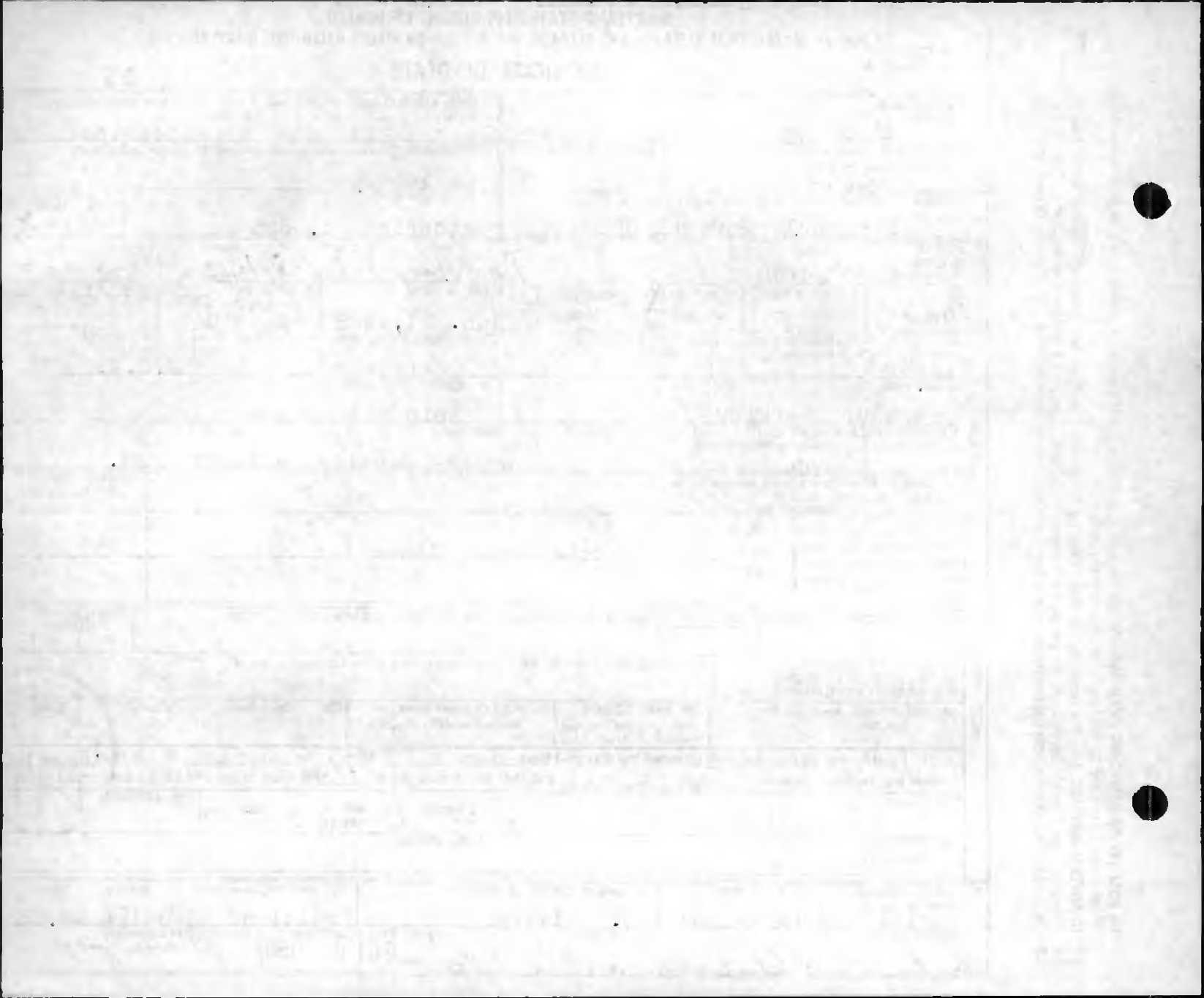
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13091

13095

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> 22.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Catherine St. 326</u>	
3. NAME OF DECEASED (Type or print) First <u>Upton</u> Middle <u>BARKLEY</u> Last <u>BARKLEY</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1929</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Upshur Barkley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Mae Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>Korea</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Sherley Barkley Salisbury Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post - Pneumothorax Hemorrhage</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 17</u> , 19 <u>67</u> , to <u>Sept 29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> , 19 <u>67</u> , and that death occurred at <u>1:15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas M. Hudock</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/4/ 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	23d. LOCATION (City or Town) (County) (State) <u>Fruitland Wicomico Md.</u>
24. FUNERAL DIRECTOR <u>Christie E. Stewart Salisbury Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3, Page 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13092

13096

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 109 Hartwood Drive				d. STREET ADDRESS 109 Hartwood Drive			
3. NAME OF DECEASED (Type or print) First RICHARD Middle NMN. Last BOXLER				4. DATE OF DEATH Month 9 Day 22 Year 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 4-20-26	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 11 Days 19	IF UNDER 24 HRS. Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA.		
13. FATHER'S NAME VIRGIL P. BOXLER			14. MOTHER'S MAIDEN NAME DELANE KINNEY CHIPMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WART			16. SOCIAL SECURITY NO. 221-14-4934		17. INFORMANT DELANE M. CHIPMAN - SEAFORD DEL.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 Coronary occlusion DUE TO (c) 4201 Coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)		(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Sept. 23, 1967		
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.			Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BORIAL SEPT 25 1967		23b. DATE THEREOF SEPT 25 1967		23c. NAME OF CEMETERY OR CREMATORY LAUREL HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) LAUREL, DELAWARE	
24. FUNERAL DIRECTOR PAYNTER & WATSON				25a. REC'D BY REGISTRAR SEP 27 1967		25b. REGISTRAR'S SIGNATURE [Signature]	
Paynter & Watson Funeral Home, Seaford, Del.							

John R. [unclear]

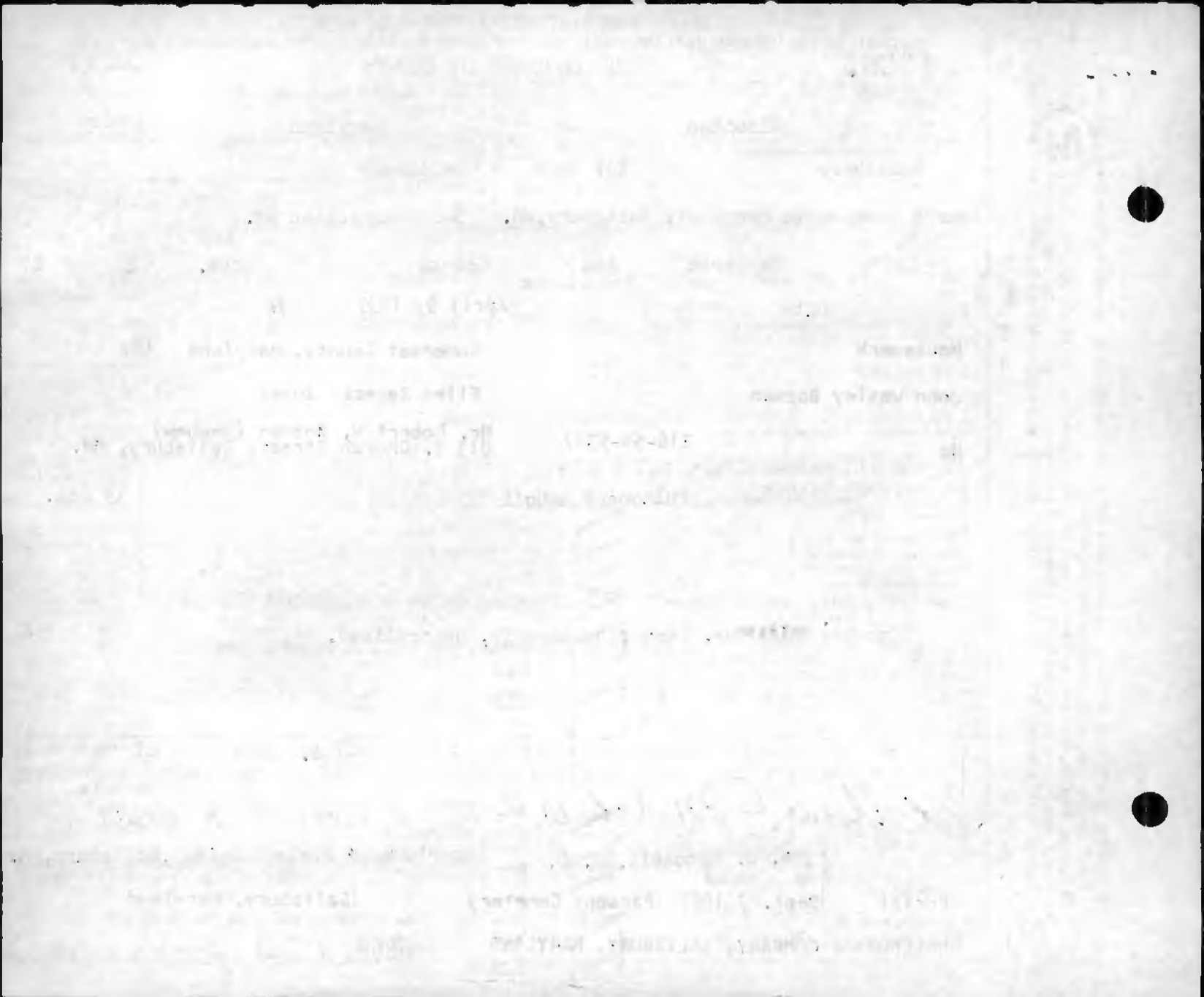
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13093 CERTIFICATE OF DEATH 13097

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>187 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> <u>22-1</u>	
f. STREET ADDRESS <u>305 Washington St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Ann</u> Last <u>Bozman</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>4</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1897</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Wesley Bozman</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Rebecca Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-54-9367</u>	
17. INFORMANT <u>Mr. Robert W. Bozman (Nephew)</u> <u>813 E. Church Street, Salisbury, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr.</u> <u>Diabetes mellitus. Arteriosclerosis, generalized.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>67</u> to <u>9/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/4</u> , 19 <u>67</u> , and that death occurred at <u>2:00</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. C. Mitchell</u> M.D.		22b. DATE SIGNED <u>9/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 7, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabs on pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1009

CERTIFICATE OF DEATH

13098

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frankford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Mary Long</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-20-1882</u>
9. AGE (In years <u>85</u> yrs)		10. F UNDER 1 YEAR Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Eber Long</u>		14. MOTHER'S MAIDEN NAME <u>Luthenia Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>221-24-2185</u>	
17. INFORMANT <u>Clifton Brasure, Frankford, Del.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO <u>Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Operation for Ovarian Cyst</u> (c) <u>Carcinoma Head of Pancreas, Coronary Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Head of Pancreas, Coronary Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred on <u>3 A</u> M, from causes on and on the date stated above.		22a. SIGNATURE <u>Robert Chris Lensen</u> M.D.	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-13-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Carey's Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Frankford, Sussex, Del.</u>	
24. FUNERAL DIRECTOR <u>W Douglas Nelson, Frankford, Del.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

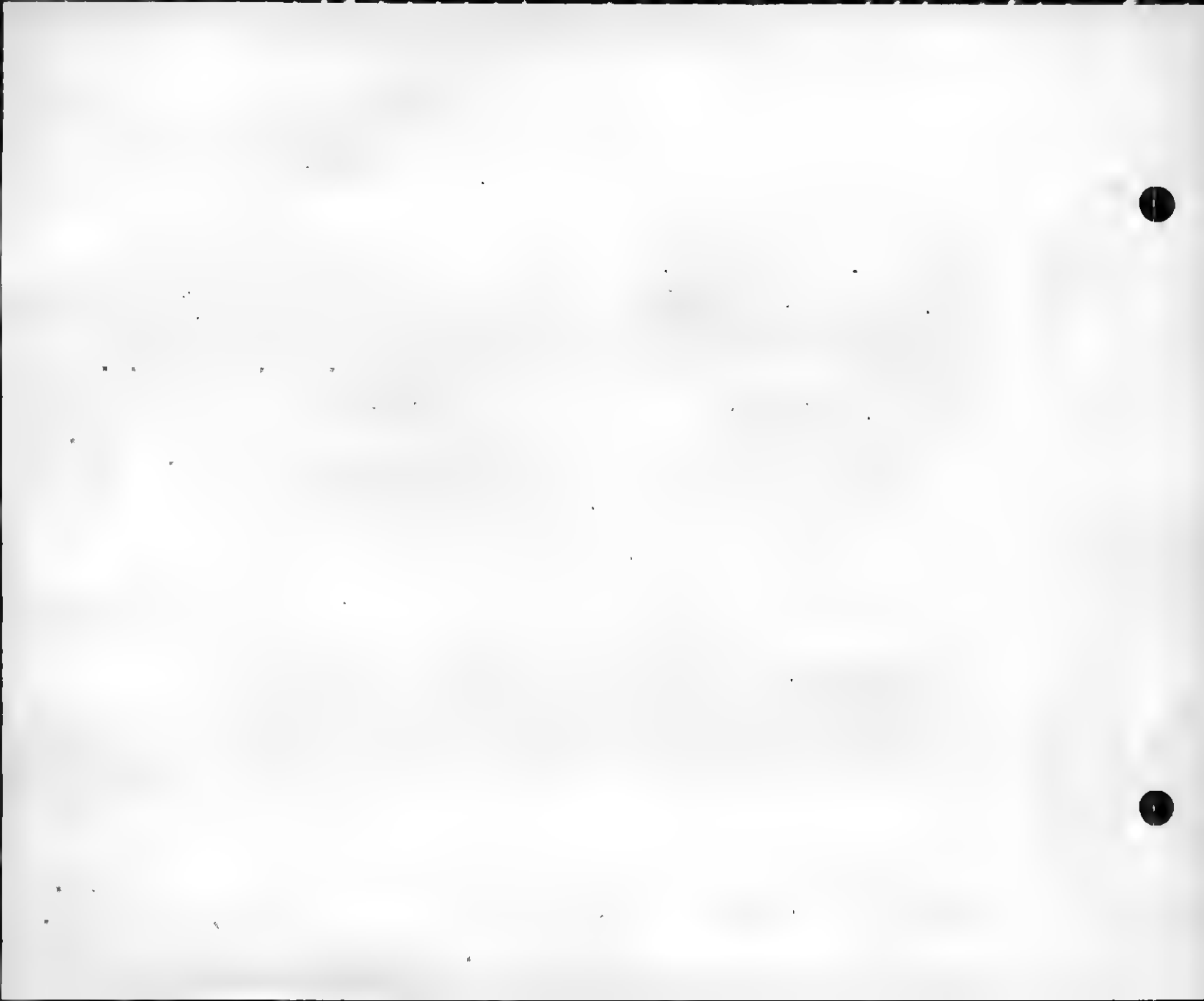
CERTIFICATE OF DEATH

13099

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Rural Crisfield</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>	
3. NAME OF DECEASED (Type or print) <u>Rodney Dale Brittingham</u> First Middle Last		4. DATE OF DEATH <u>September 25</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi cab</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Gordy Brittingham</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Pusey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rodney Dale Brittingham Jr. Crisfield</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>perforated Acute Appendicitis</u> DUE TO (b) <u>Generalized Peritonitis</u> DUE TO (c) <u>Severe pulmonary atelectasis & infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>3:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Nabil F. Warsal</u>		22b. DATE SIGNED <u>9-26</u>	
22c. PHYSICIAN'S NAME (Type) <u>NABIL F. WARSAL</u>		22d. ADDRESS <u>Peninsula General Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunnyridge</u>	23d. LOCATION (City or Town) (County) (State) <u>Hopewell, Somerset Co. Md.</u>
24. FUNERAL DIRECTOR <u>James L. Linneman</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

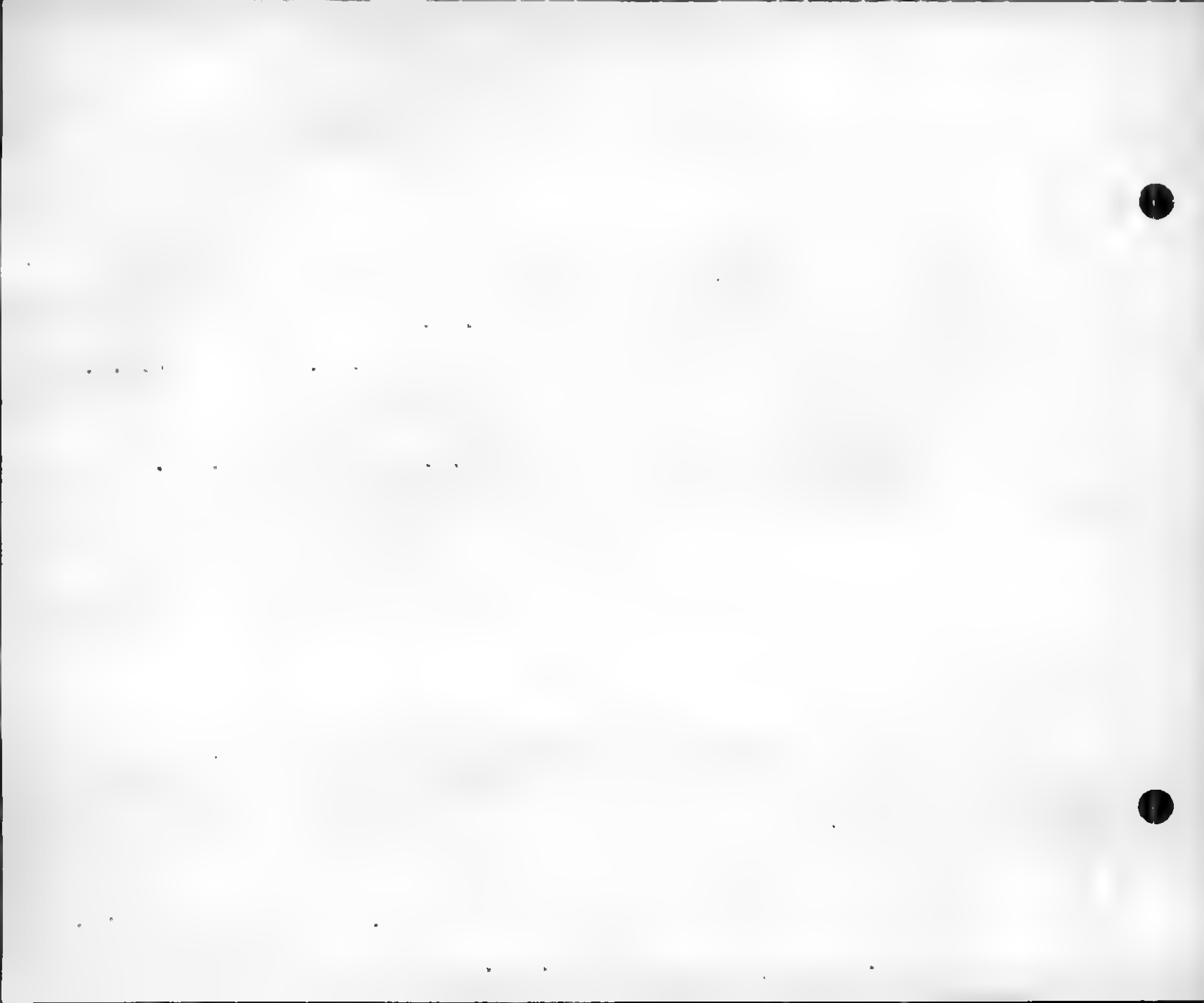
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #0 Film #3393 9/27/67 ph

CERTIFICATE OF DEATH

13036

13100

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS EDEN			
3. NAME OF DECEASED (Type or print) Drumella Virginia Bromley				4. DATE OF DEATH Month September Day 16 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 22, 1900	9. AGE (In years last birthday) 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WESTOVER, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME OTIS GREEN			
14. MOTHER'S MAIDEN NAME JENNIE DRYDEN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT JOHN W. BROMLEY EDEN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANAPLASTIC CARCINOMA, Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 6 mths			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 9-12 , 1967, to 9-16 , 1967, that (I) (we) last saw the deceased alive on 9-15 , 1967, and that death occurred at 12 M, from causes on and on the date stated above.			
22a. SIGNATURE Robert J. J. J.				22b. DATE SIGNED 16 Sept 67		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL				23b. DATE THEREOF 9/19/1967		23c. NAME OF CEMETERY OR CREMATORY SALEM METHODIST CEM.	
23d. LOCATION (City or Town) (County) (State) POCOMOKE CITY, MD.				24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.			
25a. REC'D BY REGISTRAR SEP 22 1967				25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

VII A15 (4)
20 M 1/66

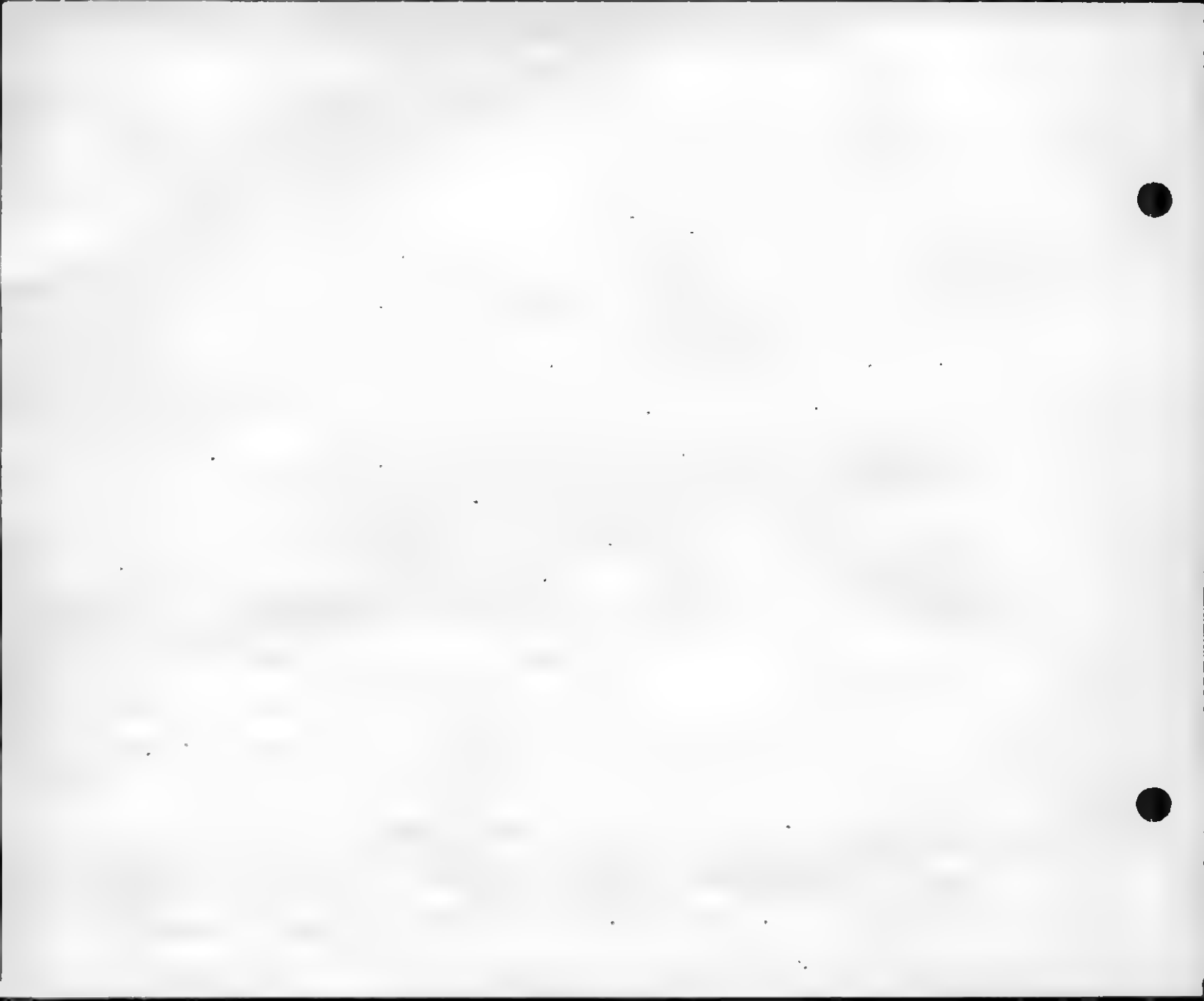
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13101

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d STREET ADDRESS <u>RFD</u>	
3 NAME OF DECEASED (Type or print) <u>PENIAMIN First LAUREL CE Middle BROCK Last JR.</u>		4 DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>4</u> Year <u>1967</u>	
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>ne-ro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 27, 1903</u>
9 AGE (In years last birthday) <u>64</u> yrs		10 IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Marvil Package Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Georgia</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin L. Brown, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Maria (maiden name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-16-7504</u>	
17. INFORMANT <u>Lula M. Brown, Laurel, Del., Box 291, RFD 3</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Left Ventricular Hypertensive</u> DUE TO (c) <u>Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>Not Known</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/30/1967</u> to <u>9/4/1967</u> that (I) (we) last saw the deceased alive on <u>9/4/1967</u> and that death occurred at <u>11:30 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>[Signature]</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Nebo Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Delmar Delaware</u>
24 FUNERAL DIRECTOR <u>J. J. Frempton and Son, Federalsburg, Maryland</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>SEP 6 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13092

13102

1 PLACE OF DEATH a. COUNTY <u>Wiconico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wiconico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R.F.D. Box 85</u>	
3 NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Charolett</u> Last <u>Brown</u>		4 DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10-26-1892</u>
9a. AGE (In years last birthday) <u>74</u> yrs		9b. IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sharptown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oliver Smiley</u>		14. MOTHER'S MARDEN NAME <u>Gayella</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Irene Harman</u>		Address <u>Maryland Spring R.F.D. Box 85</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-16</u> , 19 <u>67</u> , to <u>9-17</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>9-17</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Clifford</u>		22b. DATE SIGNED <u>9-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James R. Clifford</u>		22d. ADDRESS <u>Medical Center Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>Burial</u>	<u>9-23-67</u>	<u>At Zion</u>	<u>Sharptown Wico Md.</u>
24. FUNERAL DIRECTOR <u>Louella B. Jolley</u>		25a. REC'D BY REGISTRAR <u>Rt. 2, Jersey Rd. Salisbury, Md.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>SEP 22 1967</u>	



FOR STATE
HEALTH DEPT.

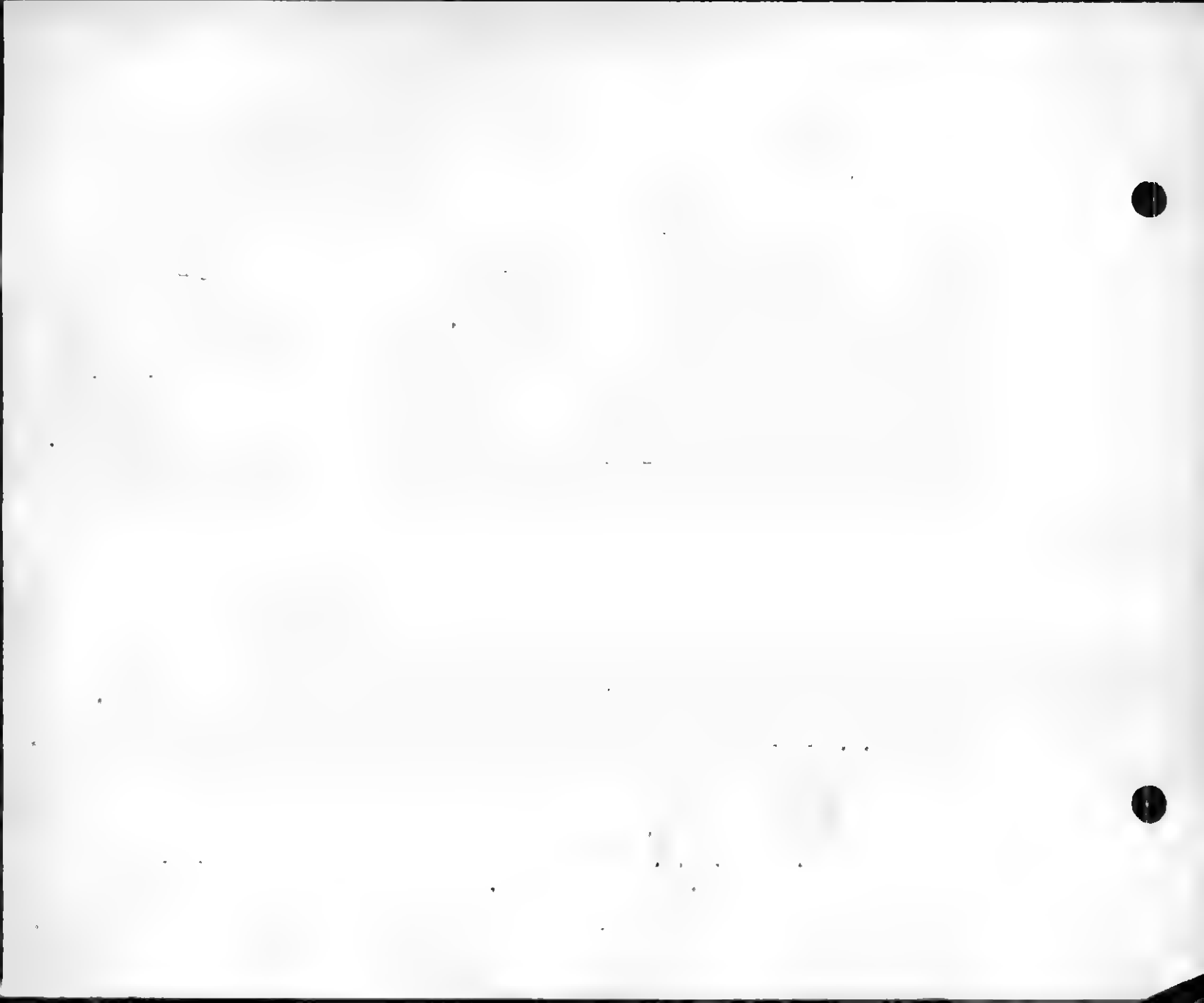
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13103

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharptown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Cooper Mill Road	
3. NAME OF DECEASED (Type or print) First Gladys Middle L Last Brown		4. DATE OF DEATH Month 9 Day 16 Year 67	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1913
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months 1 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME *Levin* Holbrook Levin Holbrook		14. MOTHER'S M.A.DEN NAME Maggie Peters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-14-4695	
17. INFORMANT Thelma Justice		Address Salis-Md. 730 Richmond Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical spine 8304 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pedestrian was crossing yard and was struck by car.	
20c. TIME OF INJURY Month, Day, Year Hour 9:30 PM 9-16-67		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> Yard of home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Sharptown		20f. (City or town) (County) (State) Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 9-18-67	
EXAMINER'S NAME (Type) 109 Camden Ave. Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/20/67	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION (City or town) (County) (State) Sharptown Wicomico Md.	
24. FUNERAL DIRECTOR Clinton H. Stewart		25a. REC'D BY REGISTRAR SEP 22 1967	
ADDRESS Salis-Md		25b. REGISTRAR'S SIGNATURE James J. [Signature]	

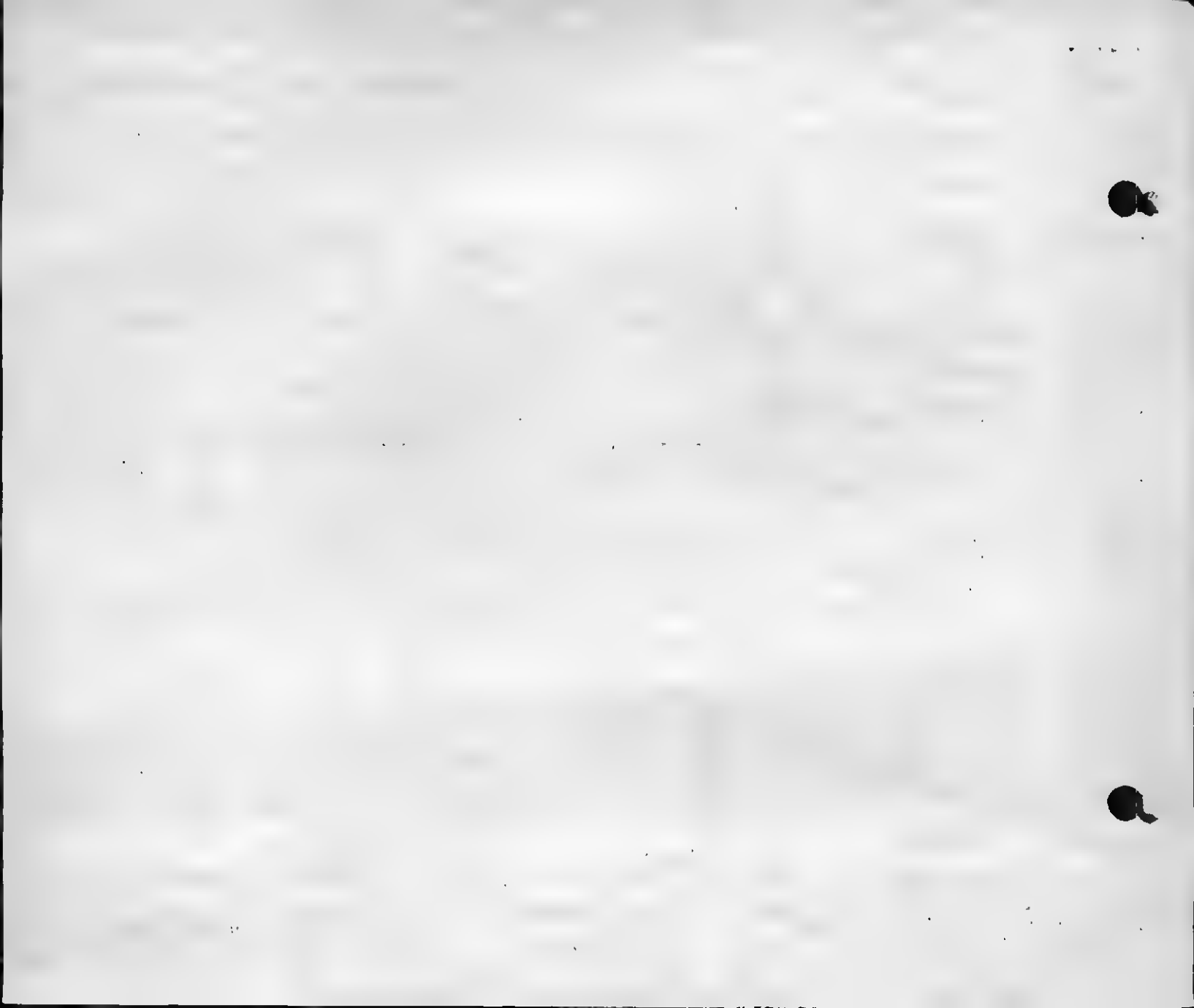


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10/19/67
BAP

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>404 Royal Street</u>					
3. NAME OF DECEASED (Type or print) <u>ROY EDWIN BROWN</u>						4. DATE OF DEATH <u>September 16 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 22, 1904</u>		9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Mason</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Eden, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marcellus L. Brown</u>						14. MOTHER'S MAIDEN NAME <u>Lottie Frances Pryor</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>220-32-0634</u>		17. INFORMANT <u>Mrs. Louise D. Brown (Wife)</u> <u>404 Royal Street, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANAPLASTIC CARCINOMA - Lung</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				
21. I certify that (I) (this hospital) attended the deceased from <u>8</u> App. <u>1967</u> to <u>9-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-16</u> , 19 <u>67</u> , and that death occurred at <u>5</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Dr. Robert L. Adkins</u>						22b. DATE SIGNED <u>Sept. 18 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert L. Adkins</u>		22d. ADDRESS <u>Fruitland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13101									
CERTIFICATE OF DEATH									
13105									
1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BAYSINGER TRAILER PARK					d. STREET ADDRESS Baysinger Trailer Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First HARVEY Middle FREDRICK Last CAREY					4 DATE OF DEATH Month September Day 24 Year 1967				
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH November 6, 1918		9. AGE (In years last birthday) yrs 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tech. Optician			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Fruitland, Maryland			12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Grover Carey					14. MOTHER'S MAIDEN NAME Mammie Mae Williams				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO 218-05-8736		17. INFORMANT Address Mrs. Hannah Bounds Carey (Wife) Baysinger Trailer Court, Salisbury, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cox Pulmonary (Chronic) 527.2 DUE TO (b) Left Sided Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Chronic Obstructive Airway Disease									INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 1 yr. 3 yrs.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding Upper Gastrointestinal									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21 I certify that (I) (this hospital) attended the deceased from July , 19 66 , to Sept. , 19 67 , that (I) (we) last saw the deceased alive on Sept 23 1967 , and that death occurred at 5:00 PM , from causes and on the date stated above.									
22a. SIGNATURE Rufus S. Gardner Jr. M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/24/67		
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR.					22d. ADDRESS MEDICAL CENTER, SALISBURY				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF September 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland Md.		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

FOR STATE
HEALTH DEPT.

Items 1 -21 Film 393

9-29-67 as Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13102

13106

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived) f institution Residence before adm ssion a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 227 Glen Avenue		e STREET ADDRESS 227 Glen Avenue	
3 NAME OF DECEASED (Type or print) MABEL IRENE COLLINS		4 DATE OF DEATH Month September Day 20 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 30, 1919
9 AGE (in years last birthday) 47 yrs		10 IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Adm. Assistant		10b KIND OF BUSINESS OR INDUSTRY Chamber of Commerce	
11 BIRTHPLACE (State or foreign country) Chester, Pennsylvania		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Clifford Irvin Twilley		14 MOTHER'S MAIDEN NAME Lida Rounds	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 222-05-4277	
17 INFORMANT Mr. Roland M. Collins, Jr. (Husband)		Address 227 Glen Avenue, Salisbury, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning DUE TO (b) 1x10 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) lost		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Apparently fell while repairing for bath	
20c TIME OF INJURY Month, Day, Year About 4 a.m. 9-20-67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Bathroom of own home		20f (City or town) (County) (State) Salisbury Wic. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		22. DATE SIGNED September 22/1967	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 23, 1967	
23c NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a REC'D BY REGISTRAR SEP 25 1967	
25b REGISTRAR'S SIGNATURE James Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13103

CERTIFICATE OF DEATH

13107

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill, Md. 21863</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt # Box 125 - d.d.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Robert William Corbin</u>		4 DATE OF DEATH Month Day Year <u>September 26 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Negro</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-22-1881</u>
9 AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Corbin</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Corbin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MAGGIE BRATTON</u>		Address <u>Rt # 2 Box 191 Snow Hill, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>4auu</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia; Anemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 25</u> , 19 <u>67</u> , to <u>Sept 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 26</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>David J. Bulmore</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Halls Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill - Wm. Md.</u>
24 FUNERAL DIRECTOR <u>Louisa B. Jolley</u>		25a. REC'D BY REGISTRAR <u>Oct 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Jersey R. R. # 2 Salisbury Md.</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

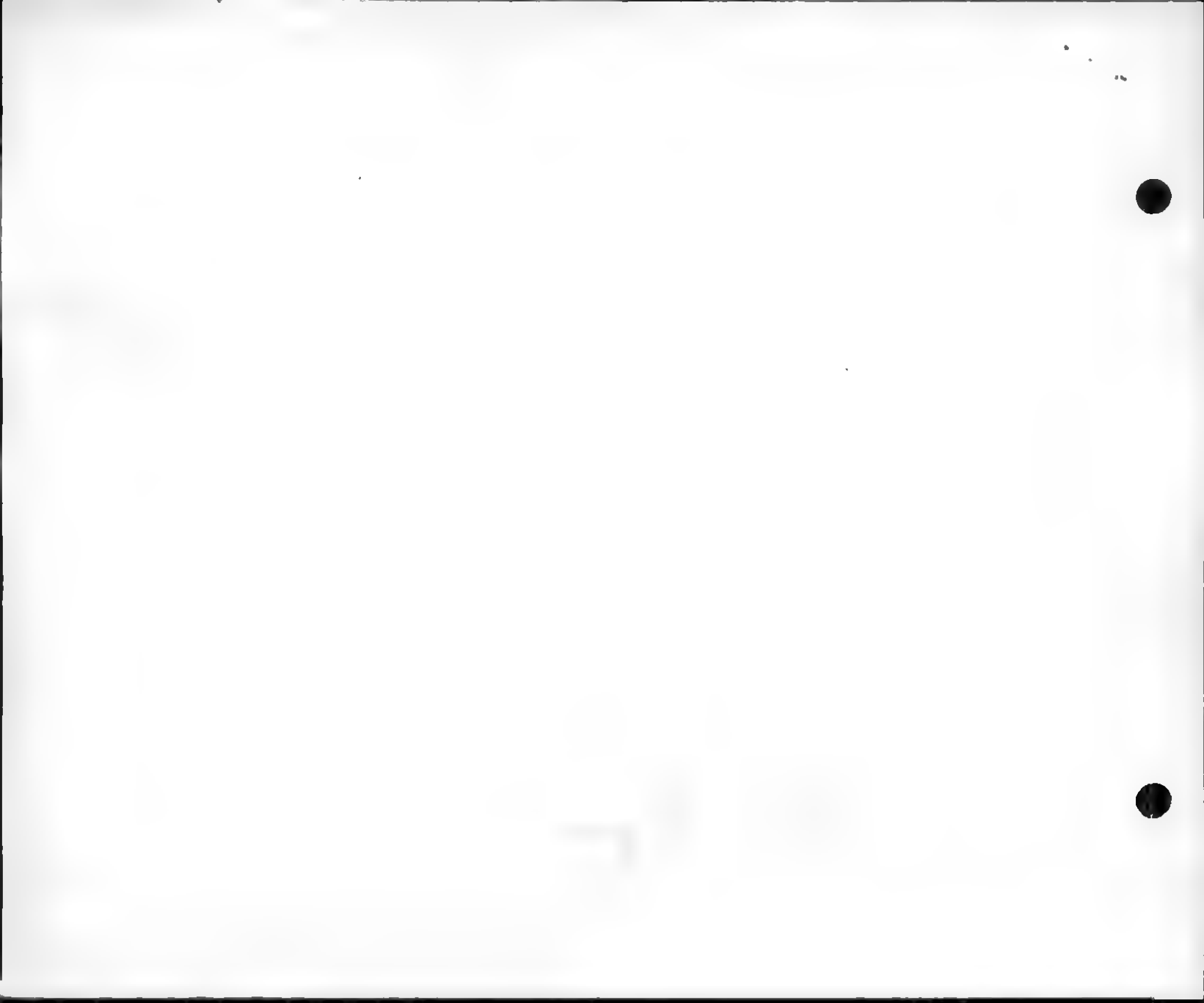
13108

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital D.O.A.				d. STREET ADDRESS 765 S. Division Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARROLL Middle LEE Last DIXON, SR.				4. DATE OF DEATH Month September Day 25 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1894	9. AGE (In years last birthday) 72 yrs	10. UNDER 1 YEAR Months 7 Days 12 Hours 15 Min.		11. UNDER 24 HRS Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery Clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Henry Dixon				14. MOTHER'S MAIDEN NAME Octavia Frances Serman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes War I		16. SOCIAL SECURITY NO 214-10-9904		17. INFORMANT Address Mrs. Nettie Ellen Dixon (Wife) 765 S. Division Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.		EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Maryland		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED September 26/1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

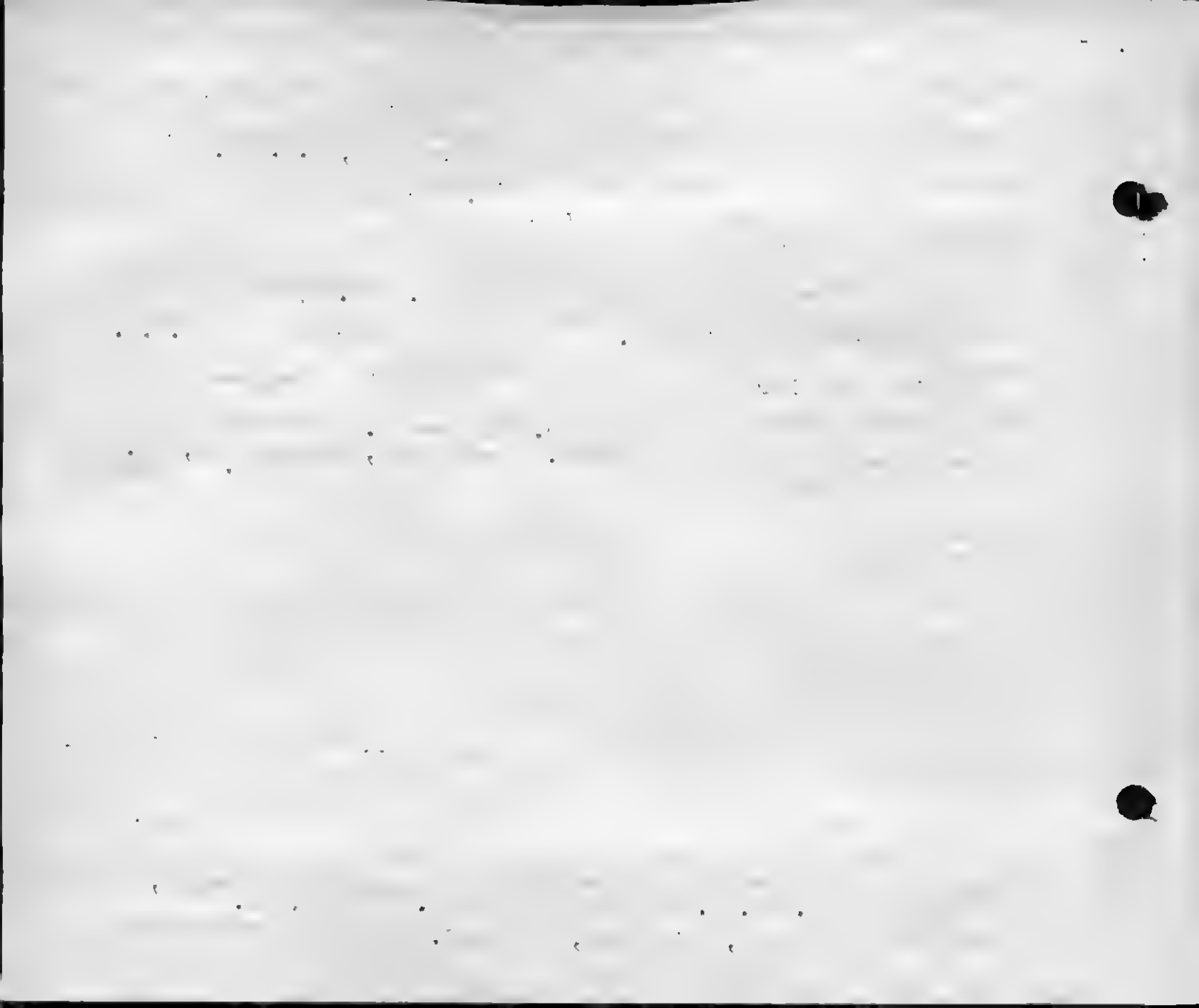
CERTIFICATE OF DEATH

13105

13109

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland b. COUNTY <u>Wicomico</u> </u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parsonsborg, R.D. #1.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springhill Private Sanitarium</u>		d. STREET ADDRESS <u>Mt. Hermon Road</u>	
3. NAME OF DECEASED (Type or print) <u>Magdalena</u>		DATE OF DEATH <u>September 10 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 20, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home.</u>	
13. FATHER'S NAME <u>William Fischer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wiegmann</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>206-14-801</u> INFORMANT <u>Mr. Alphonse B. Duchossois (son)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> 742X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Arterio-sclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from _____ App. _____ 1966 to <u>Sept. 10</u> , 1967 that (I) (we) last saw the deceased alive on <u>9-8</u> , 1967 , and that death occurred at <u>5:20</u> PM , from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip A. Insley</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Sept. 11/1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>		22d. ADDRESS <u>116 E. Main Street, Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, or other disposal <u>Burial</u>	23b. DATE THEREOF <u>Sept. 14.67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hill Side Cemetery.</u>	23d. LOCATION (City, town, or neighborhood) <u>Montgomery County, Pa.</u> (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Company, Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10106

13110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and name nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>39 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ELOISE</u> Middle <u>FIELDS</u> Last <u>FIELDS</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 4, 1888</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE MAID</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT COUNTY, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EMORY FIELDS</u>		14. MOTHER'S MAIDEN NAME <u>ROSIE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-32-2267</u>	
17. INFORMANT <u>JAMES FIELDS, ST. MICHAELS, MD.</u>		Address <u> </u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pulmonary emboli</u> <u>SSIX</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral vascular accident</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1967</u> , to <u>September 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>September 23, 1967</u> , and that death occurred at <u>11:45 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>A. C. Mitchell</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>9/25/67</u>
22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>BURIAL</u>	<u>SEPT 27, 1967</u>	<u>THOMAS MEMORIAL</u>	<u>ST. MICHAELS, MD.</u>
24. FUNERAL DIRECTOR <u>Harrison E. Leonard, St. Michael's Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

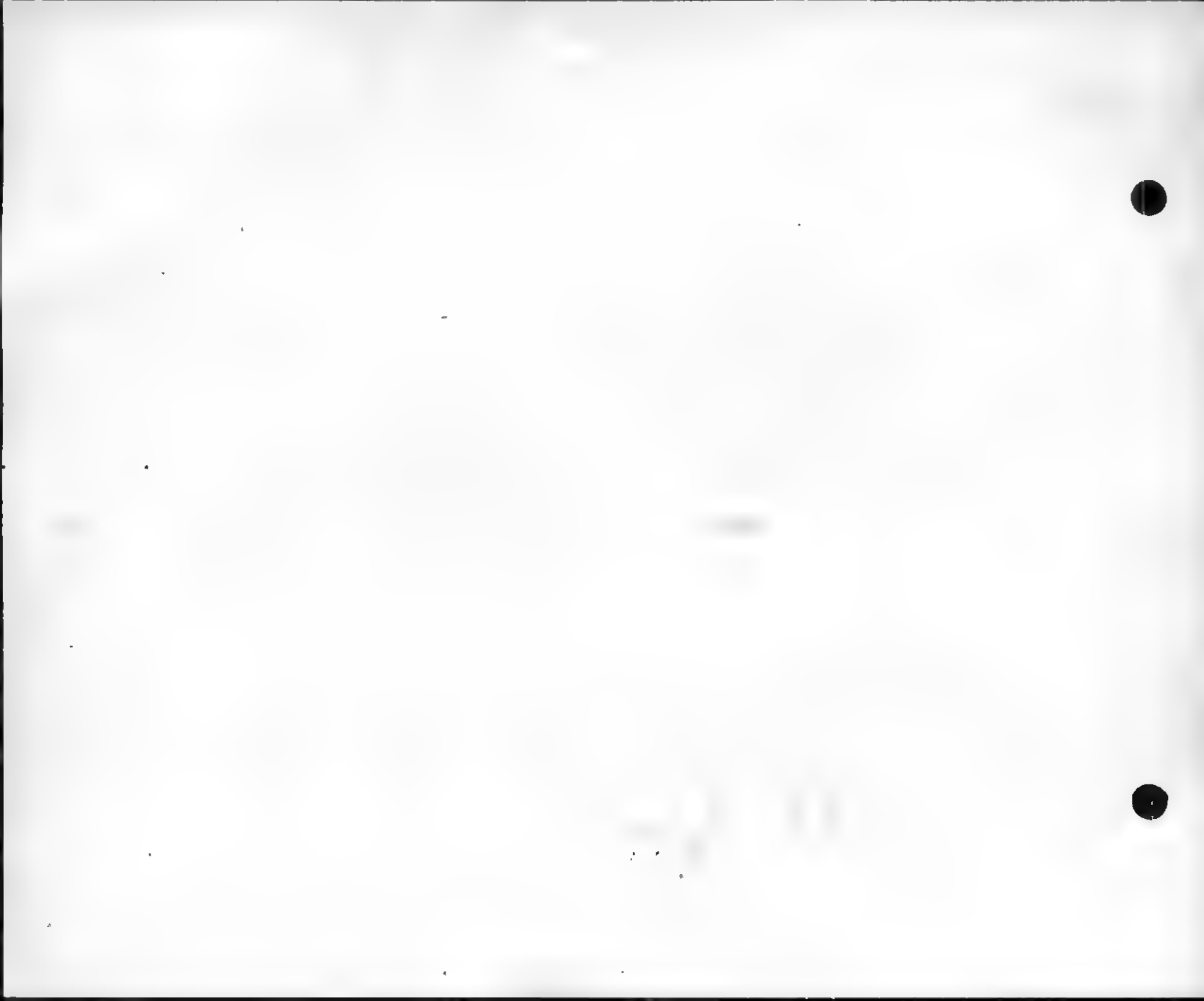
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1010

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13111

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN TB		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Peninsula General Hospital</u>			d. STREET ADDRESS <u>725 Olivia St.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>REGINALD LAGATHA FOSQUE</u>			4. DATE OF DEATH Month Day Year <u>9-14-67</u> 19		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>AA</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-14</u>		9. AGE (In years last birthday) <u>52</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>Ethel Fosque 725 Olivia St. Salisbury Md.</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pleural effusion</u> (c) <u>DUE TO</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>409 Camden Ave., Salisbury, Md.</u>		M.D.		22. DATE SIGNED <u>Sept. 16, 1967</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/17/ 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	
24. FUNERAL DIRECTOR <u>Clinton Stewart</u>		ADDRESS <u>Clinton Stewart Funeral Home, Salisbury, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

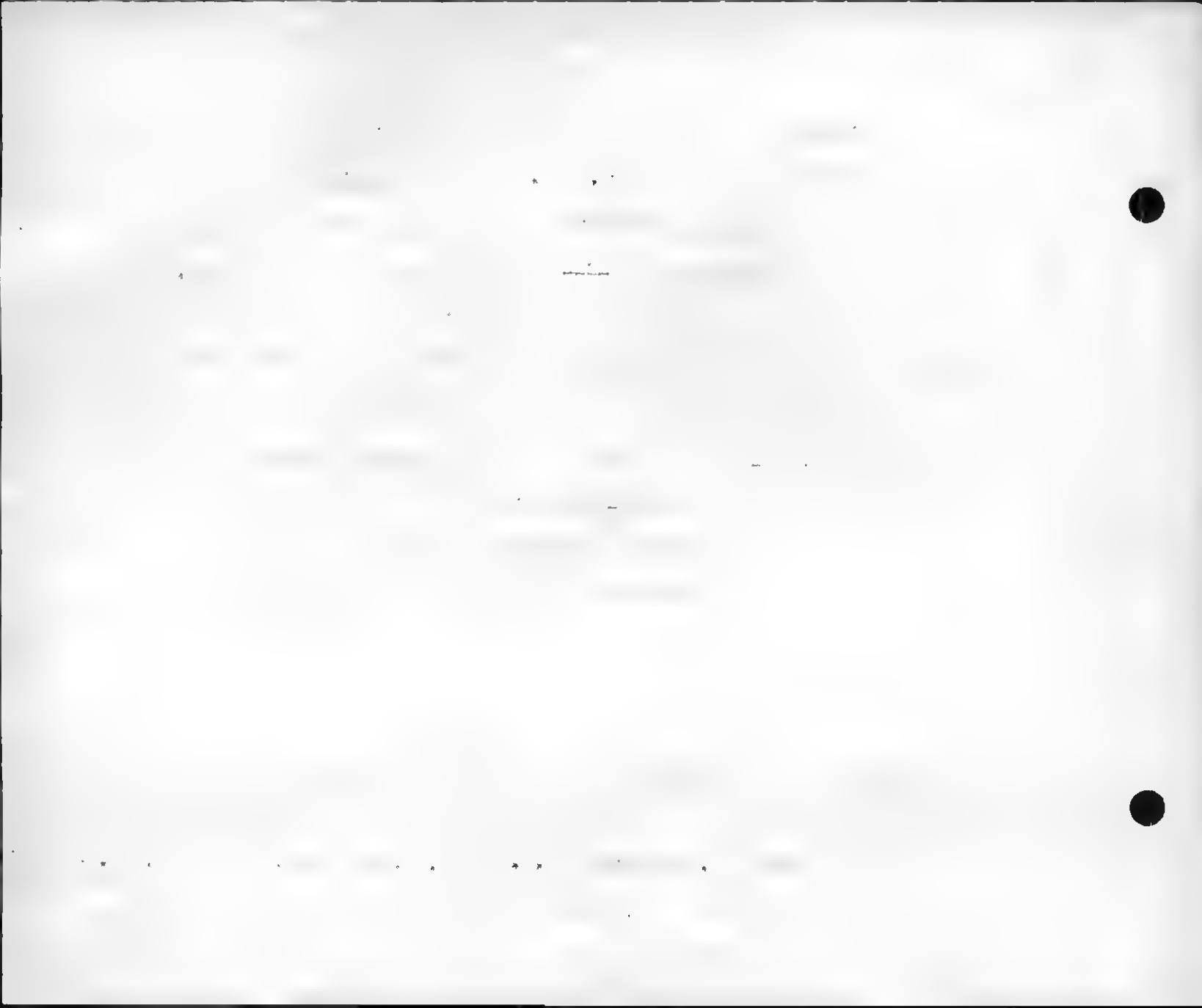
13108

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13112

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b 2Yrs. 9Mos. 25Days Cambridge	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e STREET ADDRESS 505 Byrn Street	
3. NAME OF DECEASED (Type or print) First William Middle J. Last Gatton		4. DATE OF DEATH Month Sept. Day 5 Year 19 67	
5 SEX White	6. COLOR OR RACE Male	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 23, 1890
9 AGE (In years last birthday) 77 yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman-Retired	
10b KIND OF BUSINESS OR INDUSTRY Seafood		11 BIRTHPLACE (County & State, or foreign country) Calvert County, Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Edwin Gatton	
14. MOTHER'S MAIDEN NAME Anna Elliott		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO unk		17. INFORMANT Hospital Records	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic Bronchitis DUE TO (c) Myocardial Failure			INTERVAL BETWEEN ONSET AND DEATH 3 Days Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/10/64 , 19 to 9/5/67 , 19, that (I) (we) last saw the deceased alive on 9/5/67 , 19, and that death occurred at 4:40 PM , from causes and on the date stated above			
22a SIGNATURE <i>Charles H. Winnacott</i> M.D.		22b DATE SIGNED 9/5/67	
22c PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d ADDRESS P. O. Box 2018, Salisbury, Md. - 21801	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Sept 8 1967	23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d LOCATION (City or Town) (County) (State) Cambridge, Maryland
24 FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a REC'D BY REGISTRAR SEP 7 1967	25b REGISTRAR'S SIGNATURE <i>[Signature]</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

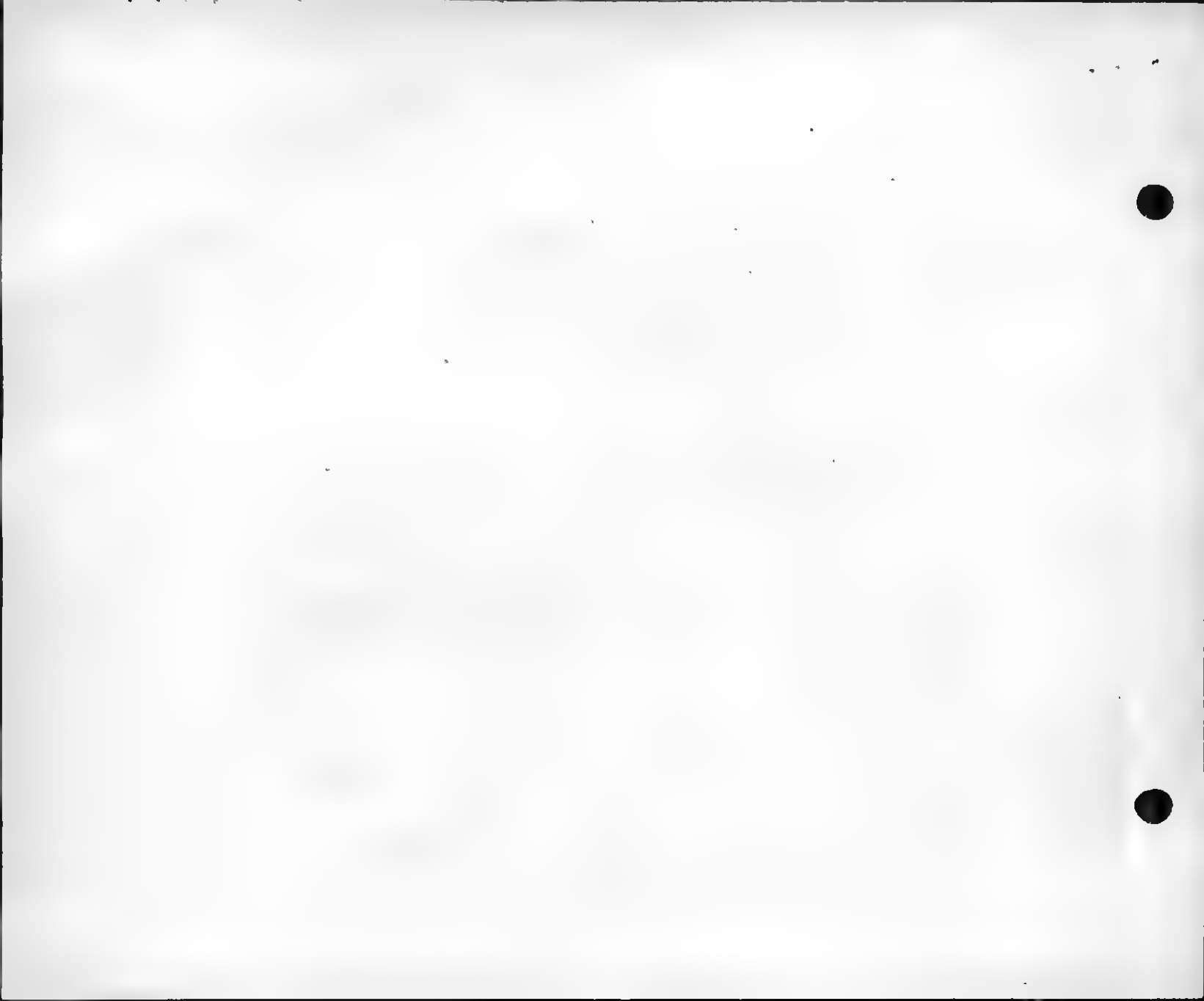
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12109

CERTIFICATE OF DEATH

13113

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Salisbury		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 408 Virginia Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle WESLEY Last GEORGE		4. DATE OF DEATH Month September Day 19 Year 1967		5 SEX Male 6 COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH January 26, 1914		9. AGE (In years last birthday) 53 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY Lumber Company	
11 BIRTHPLACE (County & State, or foreign country) Quantico, Maryland		12 CITIZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME Rev. John Peter George		14. MOTHER'S MAIDEN NAME Margaret Abbott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War II		16. SOCIAL SECURITY NO. 214-03-1474		17. INFORMANT Address Mrs. Vivian D. George (Wife) 408 Virginia Ave., Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1964							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/22, 1964 to Sept. 19, 1967 , that (I) (we) last saw the deceased alive on Sept 16, 1967 , and that death occurred at 3:05 A.M. from causes and on the date stated above.							
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED September 19, 1967		22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. RECEIVED BY REGISTRAR DATE SEP 21 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

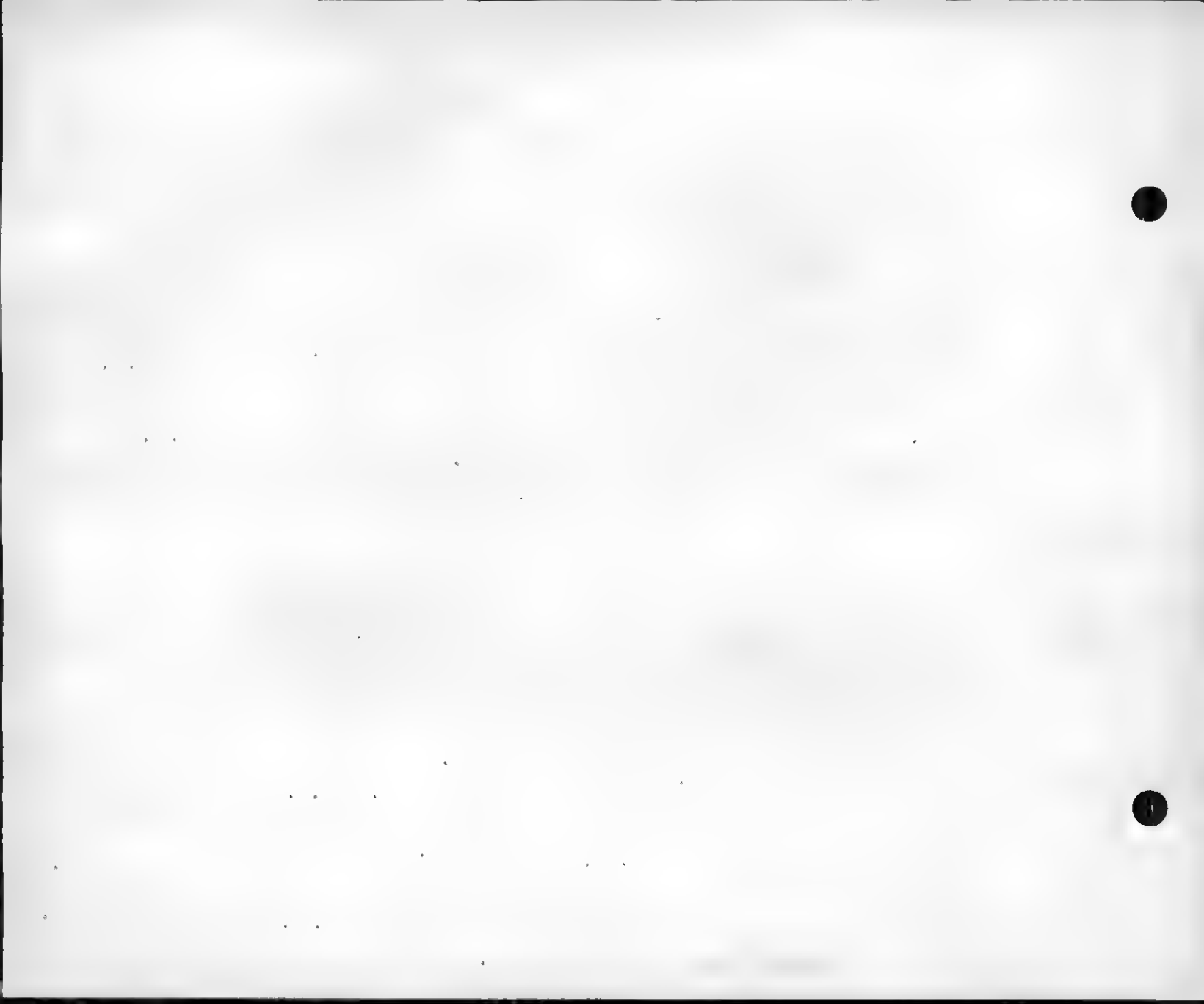
13110

13114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 11 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS 406 S. Commerce Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Gibbs Last Gibbs		4. DATE OF DEATH Month September Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/16/1885
9. AGE (n years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (County & State, or foreign country) Queen Anne's Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Gibbs		14. MOTHER'S MAIDEN NAME Sarah Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 221-18-6169	
17. INFORMANT Mrs. Maggie Tilghman		Address R.F.D. Centreville, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) QUA - Cerebral Hemiplegia 443X DUE TO (b) HASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Prostate Gland, hyper			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug. 28, 1967 , to Sept. 8, 1967 , that (I) (we) last saw the deceased alive on Sept. 8, 1967 , and that death occurred at 6:45 P.M. from causes and on the date stated above			
22a. SIGNATURE C. H. Winnacott M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 9/11/67
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVA. (Specify) Burial	23b. DATE THEREOF 9/12/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Methodist Cem. R. F. D.	23d. LOCATION (City or town) (County) (State) Centreville, Md.
24. FUNERAL DIRECTOR Anneth W. Dale		ADDRESS Chestertown, Md.	25. REGISTRAR'S SIGNATURE Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13115

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in lb 1 yr., 3 da.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
f. STREET ADDRESS 101 Green Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Earl Last Goslin		4. DATE OF DEATH Month September Day 26 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1910
9 AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY -	
11 BIRTHPLACE (County & State, or foreign country) Dorchester Co. Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elwood Goslin		14. MOTHER'S MAIDEN NAME Lillie Rumbley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-8072	
17. INFORMANT Records of Pine Bluff State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from Sept. 23, 19 66 to Sept. 26 1967 , that (b) (we) last saw the deceased alive on Sept. 26 19 67 , and that death occurred at 1:05 p.m. from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Sept. 26, 1967	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9-28-67	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	23d. LOCATION (City or Town) (County) (State) Cambridge Md.
24. FUNERAL DIRECTOR Charles R. Thomas		25a. REC'D BY REGISTRAR SEP 29 1967	
25b. REGISTRAR'S SIGNATURE John Charles Judge			



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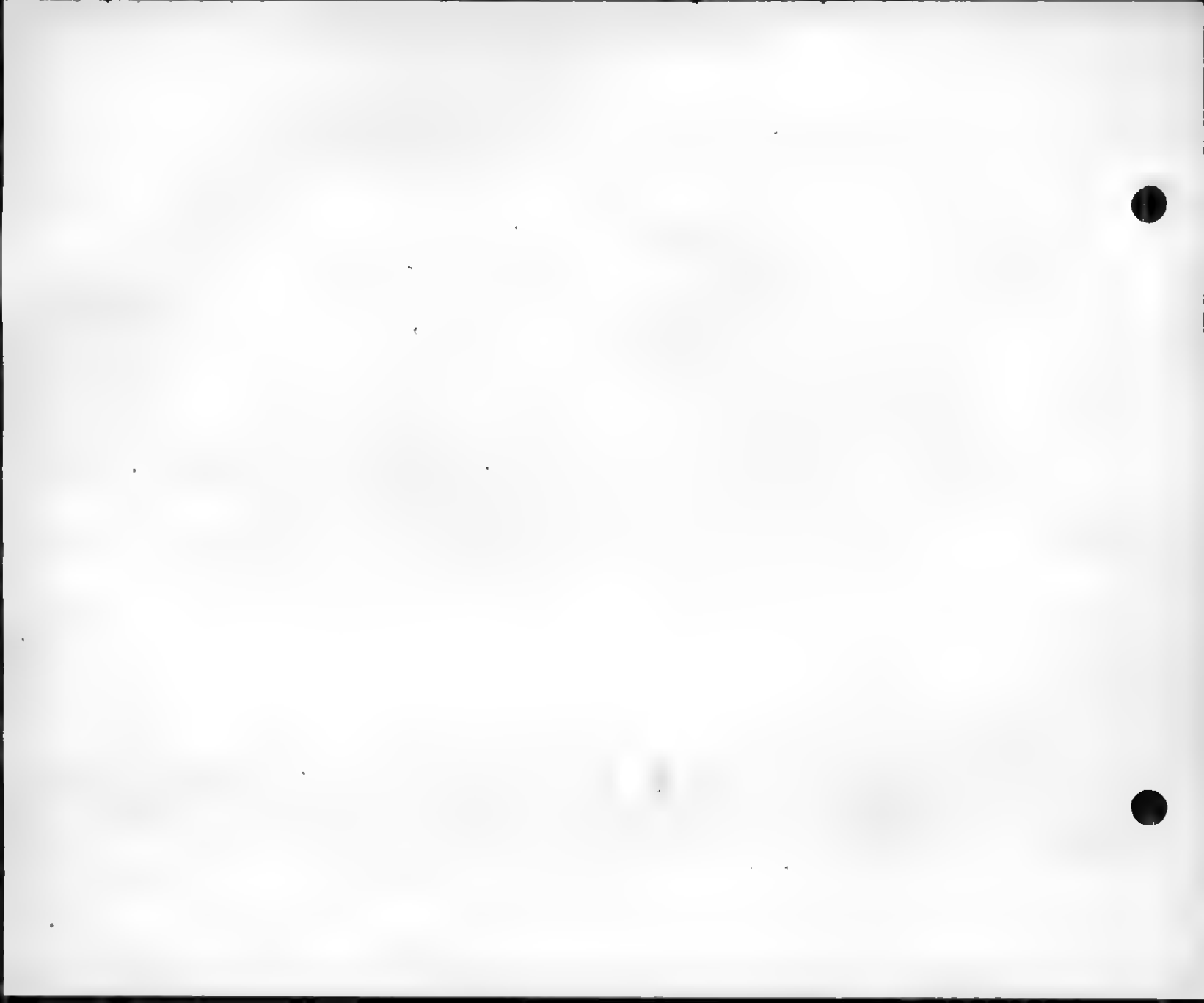
13112

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13116

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.			c. LENGTH OF STAY IN 1b 13 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			d. STREET ADDRESS 620 Edison St.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nettie Middle Griggs Last Griggs				4. DATE OF DEATH Month 9 Day 11 Year 19 67			
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1892	9. AGE (in years last birthday) 75 yrs	10. IF UNDER 1 YEAR Months Days Hours Min 	11. IF UNDER 24 HRS Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY 	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George King				14. MOTHER'S MAIDEN NAME Phillis Phillips			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 	17. INFORMANT Daniel Leonard 633 Arthur St. Salisbury Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State) 			
21. I certify that (I) (this hospital) after the deceased from 8/29 , 19 67 , to 9/11 , 19 67 , that (I) (we) last saw the deceased alive on 9/11 , 19 67 , and that death occurred at 6:00 A.M. from causes and on the date stated above.							
22a. SIGNATURE Andrew C Mitchell M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/11/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/14/ 67	23c. NAME OF CEMETERY OR CREMATORY Green Acres		23d. LOCATION (City or town) (County) (State) Salisbury Md.			
24. FUNERAL DIRECTOR Clinton F. Stewart				25a. REC'D BY REGISTRAR DATE SEP 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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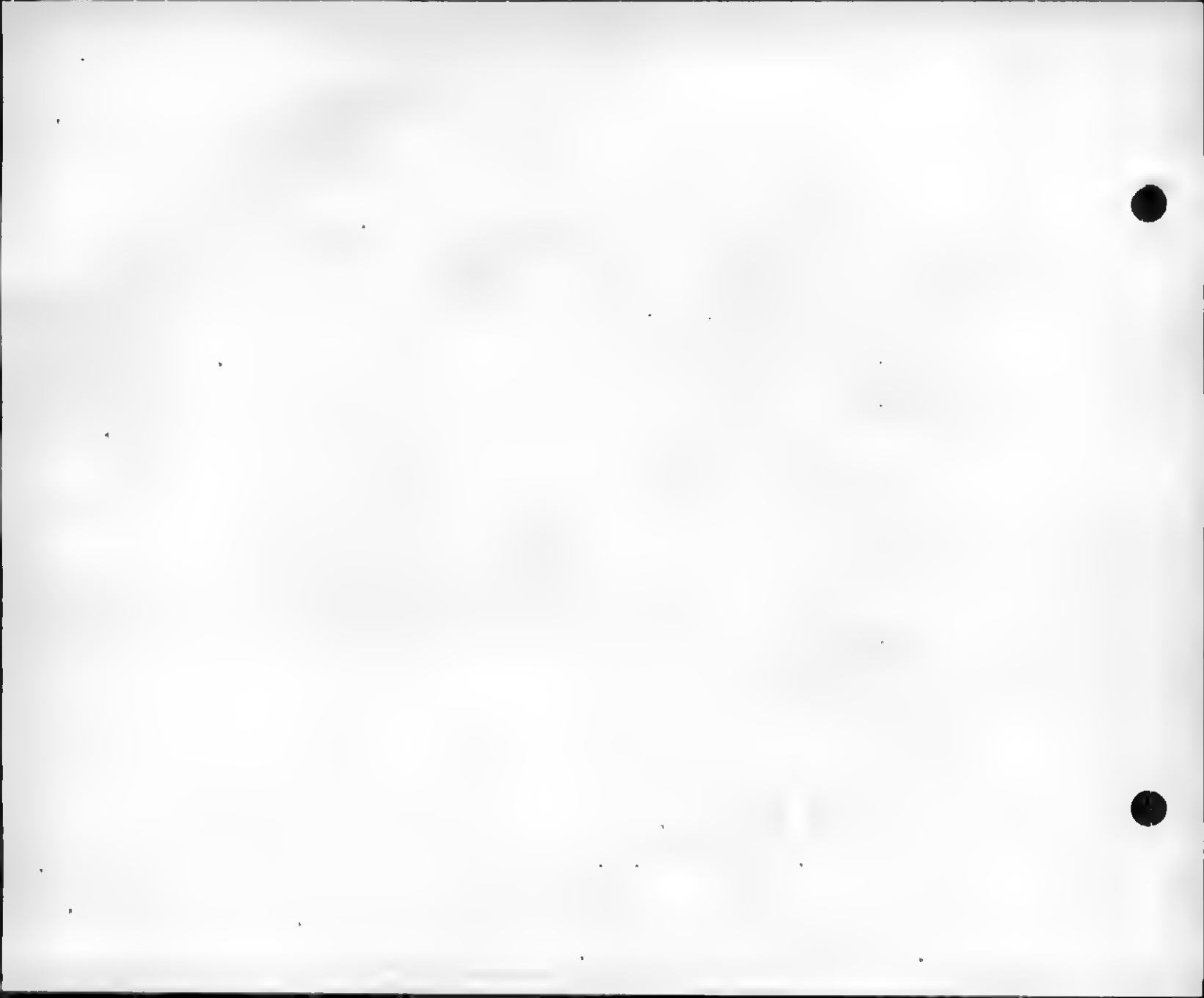
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13113

CERTIFICATE OF DEATH

13117

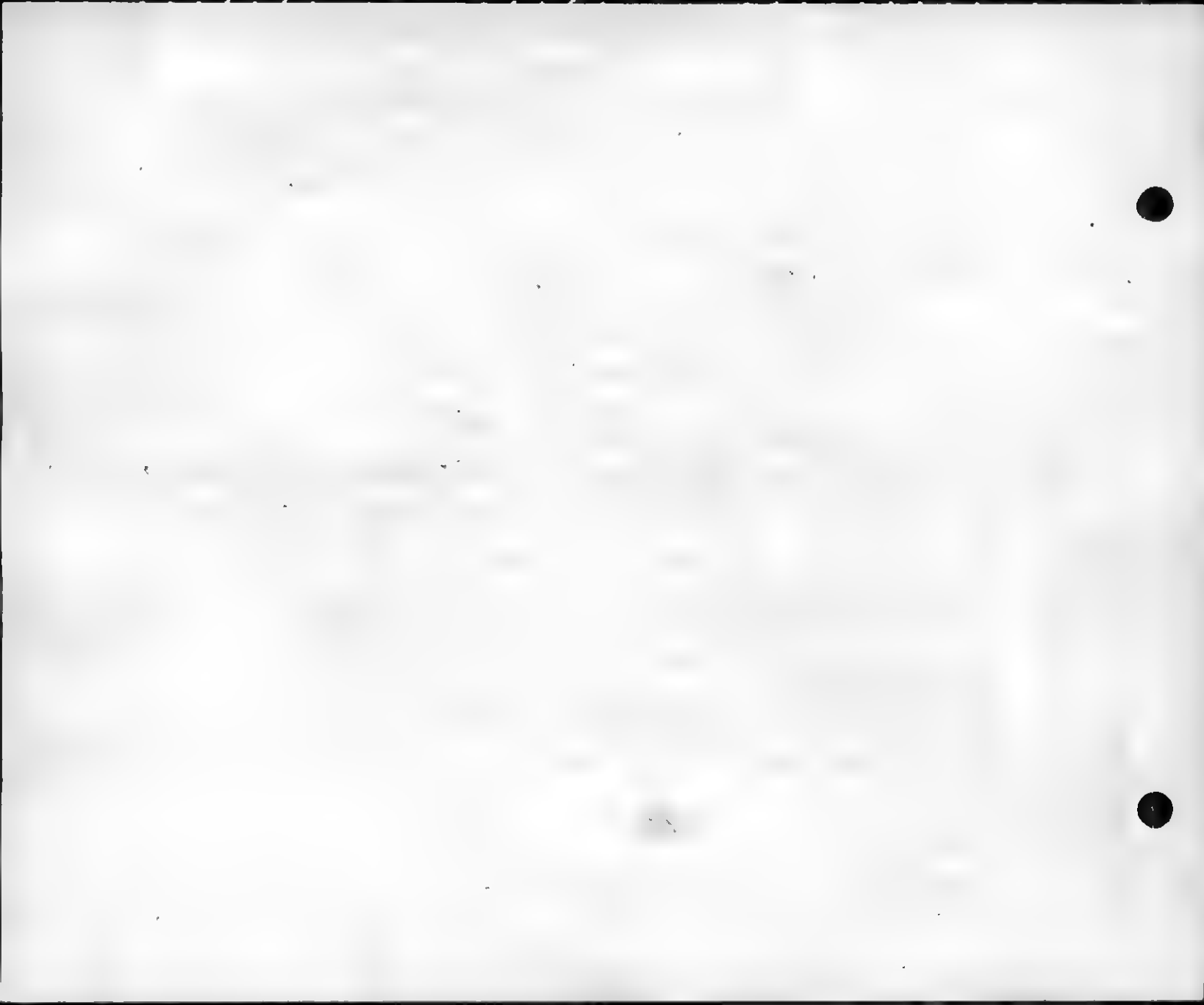
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN IT 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Rt. #3, Box 181	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle - - Last GROSS		4. DATE OF DEATH Month 9 Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-1904
9. AGE (In years lost by birthday) 63 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS. Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State or foreign country) Queen Anne Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lambert Roberts		14. MOTHER'S MAIDEN NAME Minnie Barns	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 218-30-2230-D	
17. INFORMANT Margaret Hawkins		Address RFD. Centreville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. 465Y IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of right femur		19. WAS A T.O.P.S. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (if in hospital) attended the deceased from August 21, 1967 , to September 19, 1967 , that (I) (we) last saw the deceased alive on September 19, 1967 , and that death occurred at 9:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 9/20/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 9-23-67	
23c. NAME OF CEMETERY OR CREMATORY Gross family (private Rfd. Centreville, Md.)		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR B.L. DASHIELL EASTON, MD.		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE f Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
13118									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb Life Time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, 19				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Almareta First Hayman Middle Last					4. DATE OF DEATH September 3 19 67 Month Day Year				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/8/1915		9. AGE (In years last birthday) 51 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Edward Hayman					14. MOTHER'S MAIDEN NAME Daisy Jones				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO		17. INFORMANT Address Sharley Horsey Princess Anne, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 9-3 , 19 67 , to 9-3 , 19 67 , that (1) (we) last saw the deceased alive on 9-3 , 19 67 , and that death occurred at 6:30 M, from causes and on the date stated above.									
22a. SIGNATURE William H. James Jr. M.D.					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22b. DATE SIGNED 9-3-67	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/9/67		23c. NAME OF CEMETERY OR CREMATORY Mt Hope		23d. LOCATION (City or Town) (County) (State) Princess Anne, Maryland		
24. FUNERAL DIRECTOR William H James Jr Princess Anne Md					25a. REC'D BY REGISTRAR SEP 6 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13115

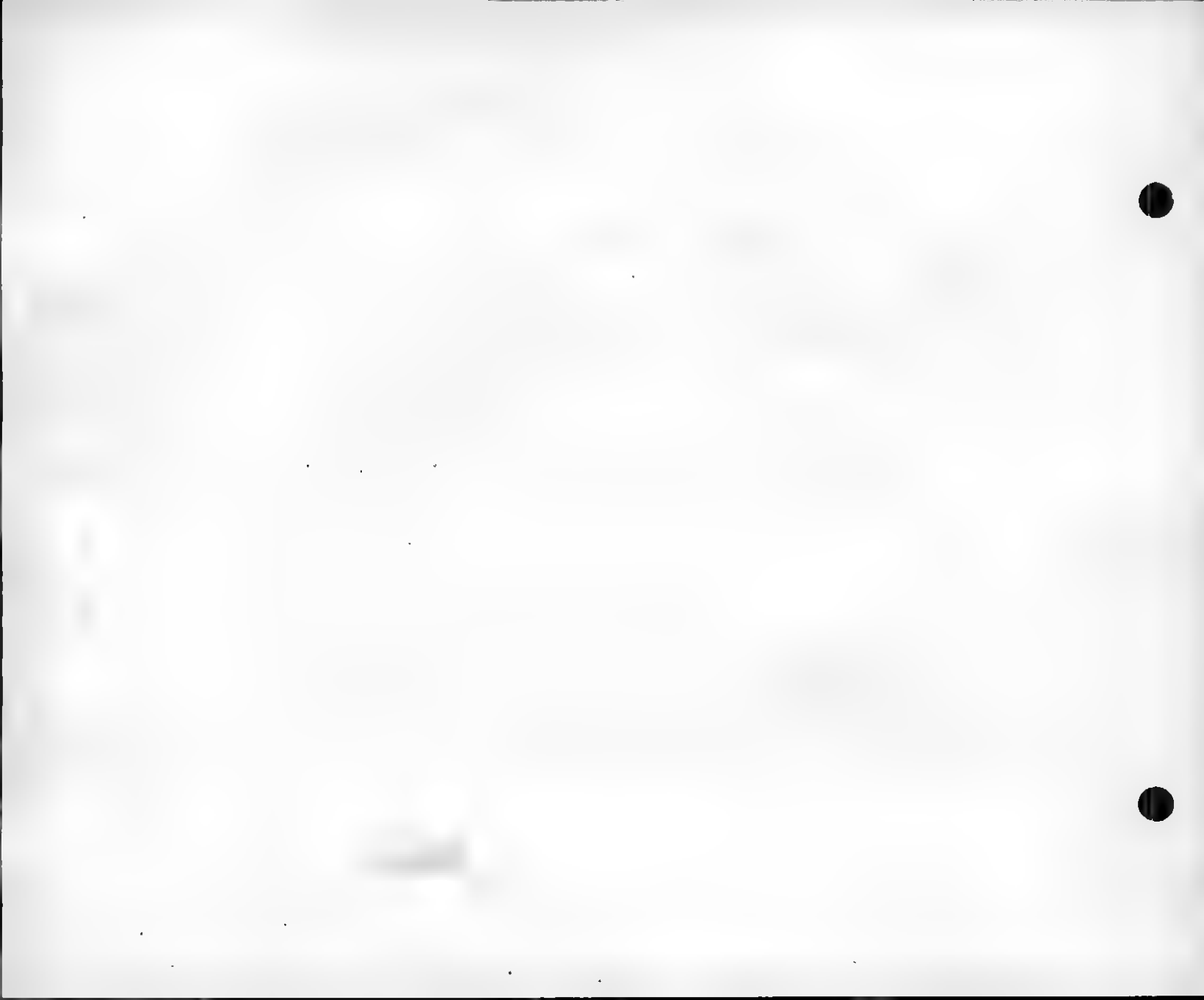
CERTIFICATE OF DEATH

13119

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>rl Sycamore</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>LULU B. HEDGES</u>		4 DATE OF DEATH Month Day Year <u>September 22 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1/24/89</u>
9 AGE (In years last birthday) <u>78</u> yrs		10 IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11c. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>S. Edmund Fanning</u>		14. MOTHER'S MAIDEN NAME <u>Annie Alfreda Fournier</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Mary L. Janosik, Laurel, Delaware</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure, Chronic</u> DUE TO <u>Myo sarcoma of bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myo sarcoma of bladder</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>Oct 22</u> , 19 <u>67</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>Oct 21 1967</u> , and that death occurred at <u>7:42</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Walter Reed</u>		22b. DATE SIGNED <u>9/22/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter Reed</u>		22d. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Laurel Del.</u>
24 FUNERAL DIRECTOR <u>W. Sharoon</u>		25a. RECEIVED BY REGISTRAR <u>SEP 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>W. Sharoon</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the birth papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
20 M 1967

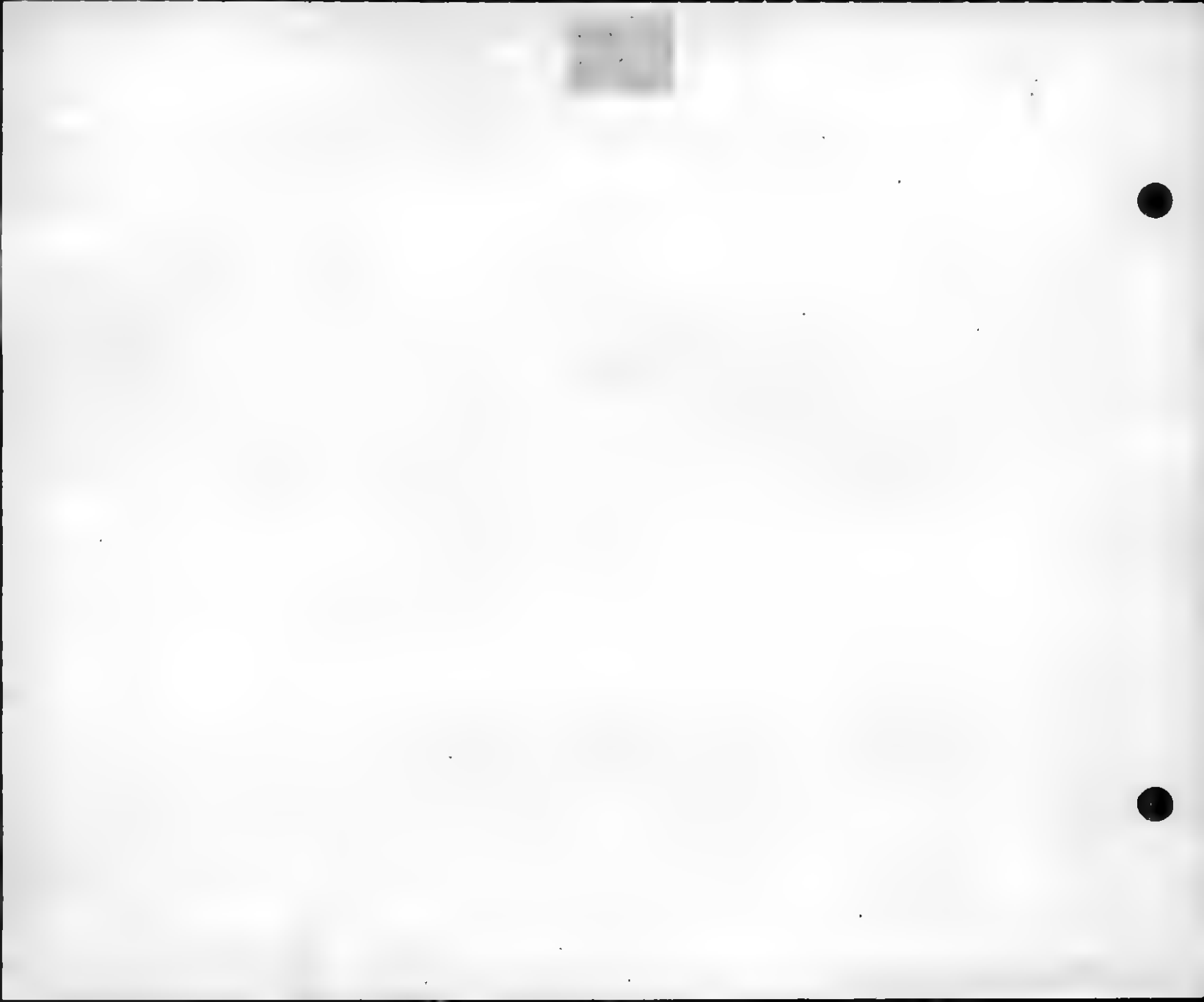
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13116

CERTIFICATE OF DEATH

13120

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>Berlin</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RT #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William James HENRY</u>				4. DATE OF DEATH Month <u>September</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-1872</u>	
9. AGE (in years last birthday) <u>95</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berlin</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Sammy Henry</u>			
14. MOTHER'S MAIDEN NAME <u>Lucy Kayne</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-14-8362</u>				17. INFORMANT <u>Lottie Williams</u> Address <u>4804 Landon Ave. Baltimore Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD & multiple small strokes</u> DUE TO (c) <u>months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10 Sept</u> , 19 <u>67</u> , to <u>20 Sept</u> , 1967, that (I) (we) last saw the deceased alive on <u>20 Sept</u> , 1967, and that death occurred at <u>7:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				22b. DATE SIGNED <u>22 Sept 67</u>		22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-25-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin Wor. Md.</u>	
24. FUNERAL DIRECTOR <u>Frederic B. Jolley</u>				25a. REC'D BY REGISTRAR <u>Oct 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

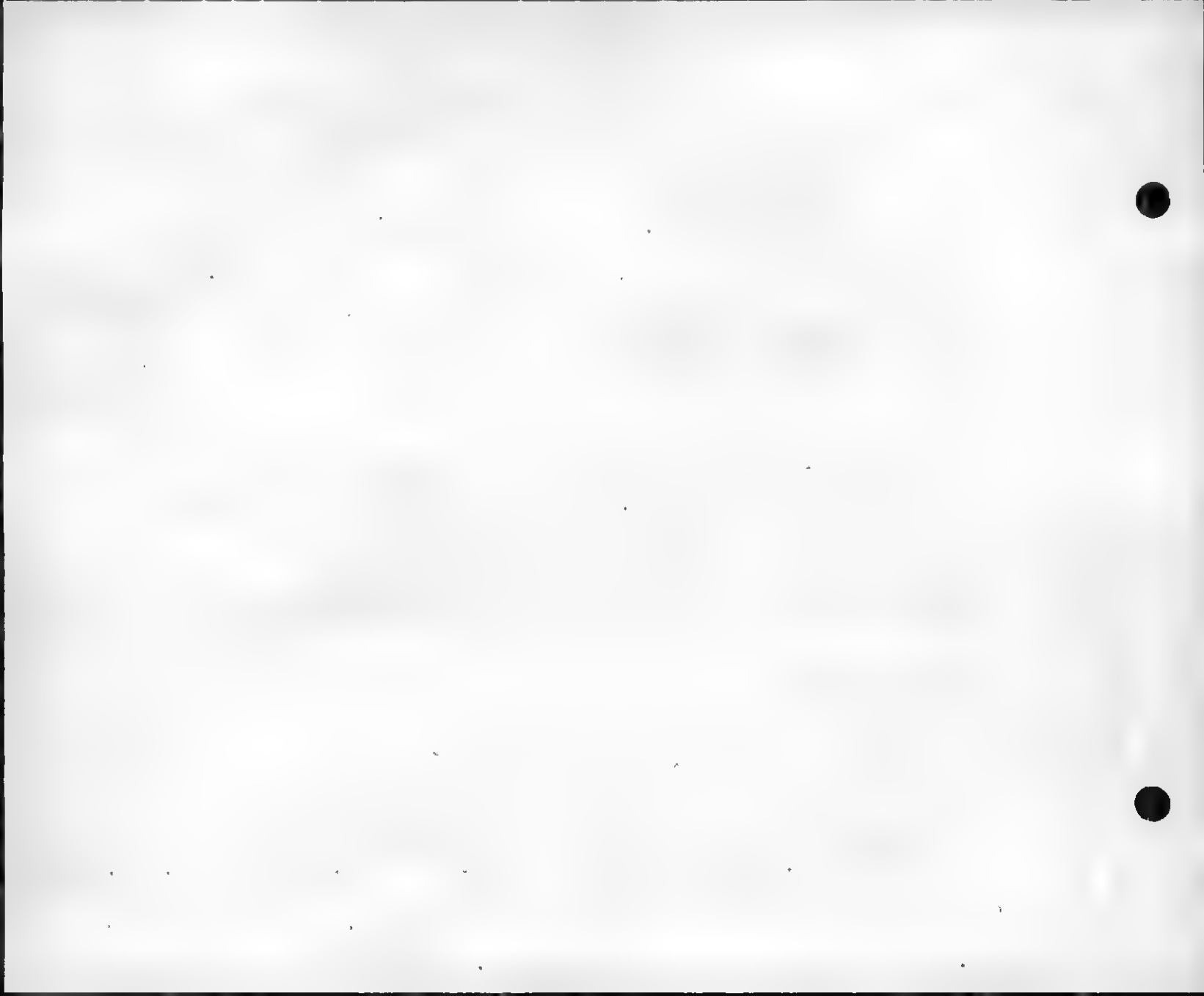
CERTIFICATE OF DEATH

13121

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c LENGTH OF STAY IN 1b <u>22 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt # 2 Robinson St.</u>		d. STREET ADDRESS <u>Collins St.</u>	
3. NAME OF DECEASED (Type or print) <u>MARY T. HILL</u>		4 DATE OF DEATH <u>Sept. 30</u> 19 <u>67</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 15, 1908</u>
9. AGE (In years last birthday) <u>59</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Major Hill, Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1 Aug. 1967</u> to <u>30 Sept. 1967</u> , that (I) (we) last saw the deceased alive on <u>30 Sept. 1967</u> and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Purnell MD</u>		22b. DATE SIGNED <u>30 Oct 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. A. Purnell MD</u>		22d. ADDRESS <u>W. Main St., Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/3/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, Md.</u>
24 FUNERAL DIRECTOR <u>Gerald C. Brown</u>		25a. RECEIVED BY REGISTRAR <u>10/3/67</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

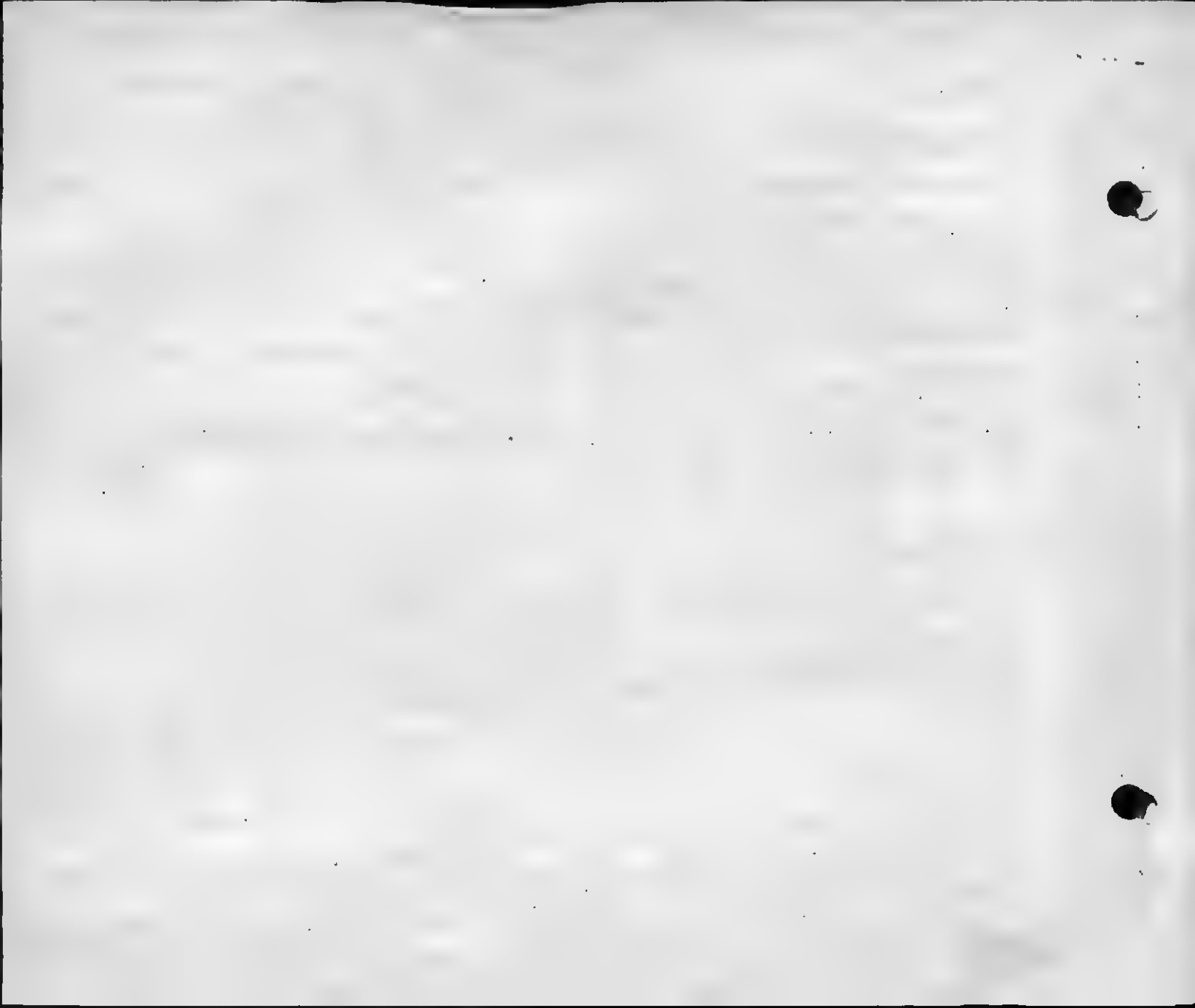
CERTIFICATE OF DEATH

13118

13122

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>703 Riverside Road</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY LEE HITCHENS</u>			4. DATE OF DEATH Month Day Year <u>September 10 1967</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 25, 1893</u>			9. AGE (in years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) <u>Sussex County, Delaware</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Peter C. Hitchens</u>			14. MOTHER'S MAIDEN NAME <u>Martha Phillips</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-18-4407-81</u>		
17. INFORMANT <u>Mrs. Aline M. Crowley (Daughter)</u> <u>416 Wilkins Street, Salisbury, Maryland</u>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>33-X</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>N/A</u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State) <u>Salisbury, Maryland</u>		
21. I certify that (I) (this hospital) attended the deceased from <u>9/9/67</u> , to <u>9/10/67</u> , that (I) (we) last saw the deceased alive on <u>9/9/67</u> , and that death occurred at <u>1 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>William D. Gray</u>			22b. DATE SIGNED <u>Sept. 11/1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>			22d. ADDRESS <u>334 Camden Ave., Salisbury, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 12, 1967</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>			25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

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CERTIFICATE OF DEATH

13110

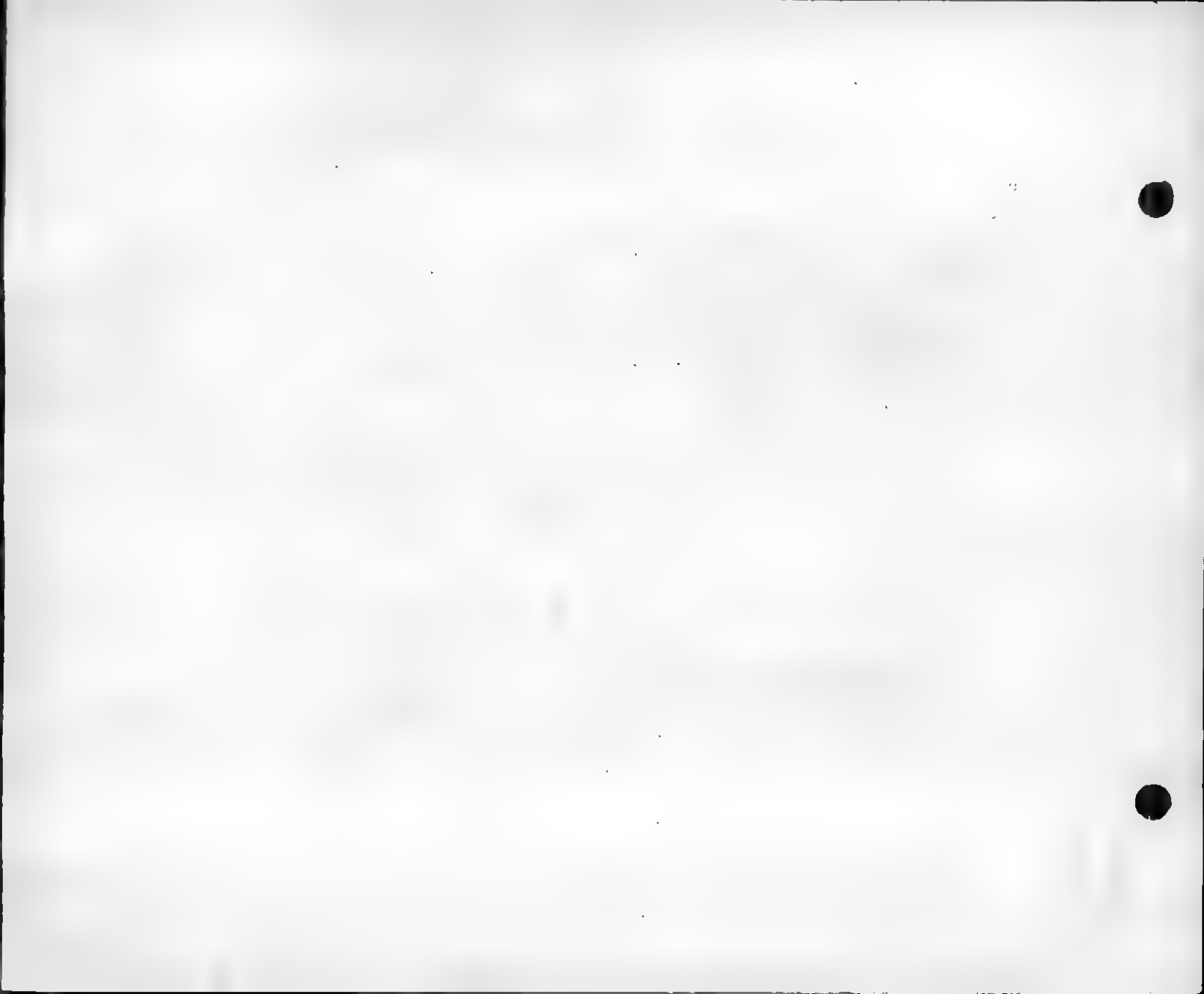
13123

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>402 Circle Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth T. Holloway</u>		4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17 1901</u>
9. AGE (In years last birthday) <u>66</u> Yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Newark Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Terman</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Stston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213 22 6803</u>	
17. INFORMANT <u>William H. Holloway</u>		Address <u>Snow Hill Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of breast</u> 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> , 19 <u>67</u> , to <u>9/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>William P. Sculler</u> M.D.		22b. DATE SIGNED <u>9/26/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 28, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old School Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Md.</u>	
24. FUNERAL DIRECTOR <u>Thomas F. Harris</u>		25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	
ADDRESS <u>Snow Hill Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>	
DATE <u>SEP 28 1967</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15
20 M 1/67



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

VR A15ME (5)
6M 1/66

10/19/67

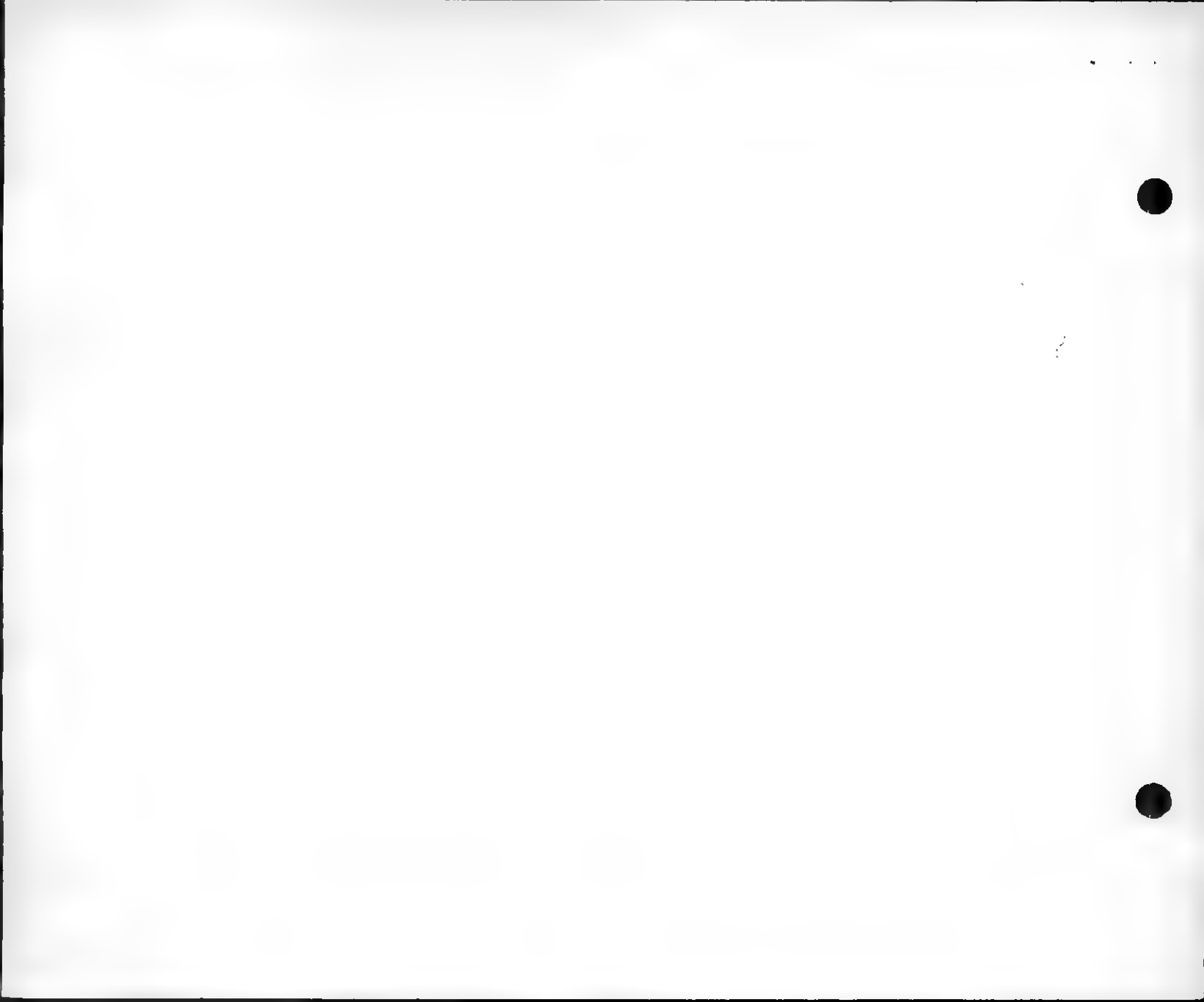
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13124

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron			c. LENGTH OF STAY in 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#1 Levin Dashiell Road			d. STREET ADDRESS R.D.#1		
3. NAME OF DECEASED (Type or print) First EDWARD Middle CLIFFORD Last HOPKINS			4. DATE OF DEATH Month September Day 27 Year 1967		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 18, 1915		9. AGE (In years lost birthday) yrs 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed		10b. KIND OF BUSINESS OR INDUSTRY Roofing	11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clifford Hopkins			14. MOTHER'S MAIDEN NAME Elnora (Nora Ellen) Phippin		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO 214-10-9587	17. INFORMANT Mrs. Ruth P. Hopkins (Wife) R.D.#1, Hebron, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. Philip A. Insley EXAMINER'S NAME (Type) 116 E. Main St., Salisbury, Md.		M.D. Dr. Philip A. Insley		22. DATE SIGNED September 28/1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF September 30, 1967	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13121

13125

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY in lb 72 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d STREET ADDRESS - - -	
3 NAME OF DECEASED (Type or print) First WILLIAM Middle RODNEY Last HORSMAN		4 DATE OF DEATH Month 9 Day 21 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/14/1888
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b KIND OF BUSINESS OR INDUSTRY Own Farm	9 AGE (In years last birthday) 78 yrs
11 BIRTHPLACE (County & State, or foreign country) Wicomico, Md		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME James W.P. Horsman		14 MOTHER'S MAIDEN NAME Suzette Anderson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 20-01-2846	
17 INFORMANT Nellie Horsman, Bivalve, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laennec's cirrhosis (far advanced) DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture, right hip			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour am p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from July 11 , 1967, to September 21 1967, that (I) (we) last saw the deceased alive on September 21 1967, and that death occurred at 9:00 AM , from causes and on the date stated above			
22a SIGNATURE C. H. Winnacott		22b DATE SIGNED 9/21/67	
22c PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d ADDRESS Deer's Head State Hospital, Salisbury, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/23/67	Bivalve Cem.	Bivalve, Wicomico, Md.
24 FUNERAL DIRECTOR Charles Judge		25a REC'D BY REGISTRAR SEP 25 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR RECORDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13122

CERTIFICATE OF DEATH

13126

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Princess Anne</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>James</u> Last <u>Howard</u>				4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3 1878</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Cecil Hall Ya</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>John Howard</u>				14. MOTHER'S MAIDEN NAME <u>Emma Henderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Mary Howard</u> Address <u>Route 2 Princess Anne Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>Arteriosclerotic cerebrovascular disease</u> stating the underlying cause last (c) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diarrhea & Pneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/26/1967</u> to <u>9/29/1967</u> that (I) (we) last saw the deceased alive on <u>9/28/1967</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Osmond Burton</u>	
22d. ADDRESS <u>Medical Center, Salisbury Maryland</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beechwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Princess Anne Somerset Md.</u>	
24. FUNERAL DIRECTOR <u>James Hanman Princess Anne</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13120

CERTIFICATE OF DEATH

13127

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>117 ...</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>M</u> Last <u>Trotter</u>		4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>...</u>
9. AGE (In years last birthday) <u>...</u> yrs		10. IF UNDER 1 YEAR Months <u>...</u> Days <u>...</u> Hours <u>...</u> Min. <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>...</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>...</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>...</u>	
13. FATHER'S NAME <u>E. T. ...</u>		14. MOTHER'S MAIDEN NAME <u>...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>...</u>	
17. INFORMANT <u>...</u>		Address <u>...</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary - 2°</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>...</u> DUE TO (c) <u>...</u>			INTERVAL BETWEEN ONSET AND DEATH <u>...</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>...</u> p.m. <u>...</u> 19 <u>...</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>...</u> , 19 <u>...</u> , to <u>...</u> , 19 <u>...</u> , that (I) (we) last saw the deceased alive on <u>...</u> , 19 <u>...</u> , and that death occurred at <u>6:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>...</u>		22b. DATE SIGNED <u>9-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>...</u>		22d. ADDRESS <u>...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>...</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>...</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 1967</u>	
ADDRESS <u>...</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13128

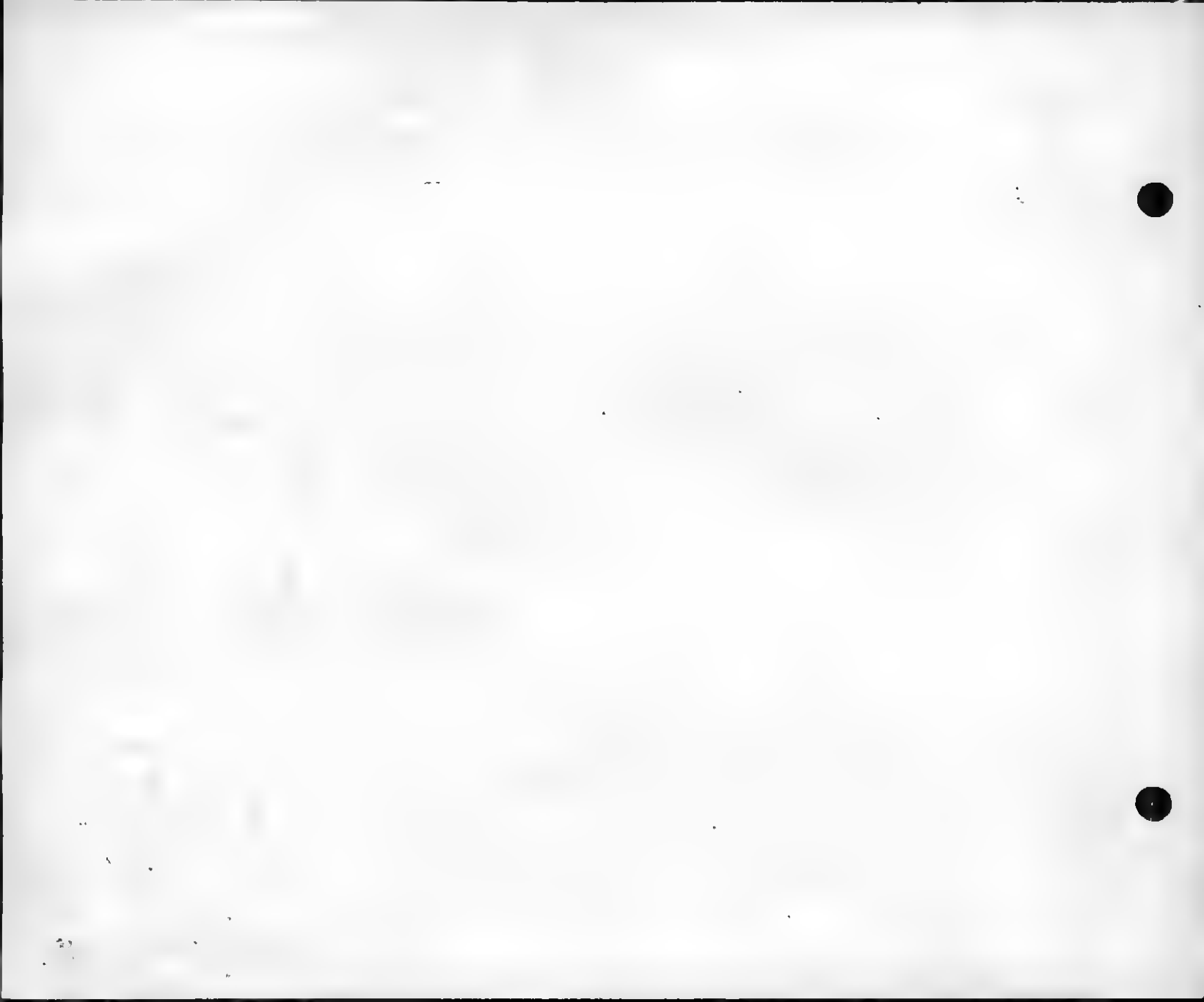
CERTIFICATE OF DEATH

13128

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WOOLFESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>5000 NEWARK</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>JOHNSON</u> Last <u>JOHNSON</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 10, 1903</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>14</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State or foreign country) <u>BERLIN, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Johnson Sr</u>		14. MOTHER'S MAIDEN NAME <u>NANCY WATERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. SERVICE WATERS, NEWARK, MD</u>		Address <u>NEWARK, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO <u>241X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>STATUS ASTHMATICUS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 1/2</u> <u>4 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 11, 1967</u> to <u>Sept 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 23, 1967</u> , and that death occurred at <u>5:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert C. Lhamar</u>		22b. DATE SIGNED <u>9/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. LHAMAR</u>		22d. ADDRESS <u>104399 SNOW HILL, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/28/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>COOKSPRINGS CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>GROHETREE, MD</u>
24. FUNERAL DIRECTOR <u>James F. Lhamar</u>		25. REC'D BY REGISTRAR <u>SEP 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13125

13129

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 5 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS Rt. 3, Box 203		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY L. JONES				4. DATE OF DEATH Month Day Year 9 10 1967			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/1890		9. AGE (In years last birthday) 77 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Lottie Anderson. Camden N.J. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 4401 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease Years (c)							INTERVAL BETWEEN ONSET AND DEATH 15 min.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from September 5, 1967 , to September 10, 1967 , that (I) (we) last saw the deceased alive on September 10, 1967 , and that death occurred at 2P M, from causes and on the date stated above.							
22a. SIGNATURE <i>A.C. Mitchell</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/11/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22d. ADDRESS Maryland Deer's Head State Hospital, Salisbury,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/67		23c. NAME OF CEMETERY OR CREMATORY St James		23d. LOCATION (City or Town) (County) (State) Oriole, Maryland	
24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md ADDRESS				25a. REC'D BY REG. STRAR DATE SEP 14 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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10/19/67

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13126

13130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 16 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1113 East Church St.				d. STREET ADDRESS 1113 East Church St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last WILLIAM JAMES KEESTER				4. DATE OF DEATH Month Day Year 9 14 1967					
5. SEX Male		6 COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-1889		9 AGE (In years last birthday) 78 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Coast Guard		11 BIRTHPLACE (County & State or foreign country) Illinois			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jamesm Harvey Keester				14 MOTHER'S MAIDEN NAME Adelaibe Wilkes					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1907-1949		16 SOCIAL SECURITY NO. 1907-1949		17 INFORMANT Richard Cullen		132 E. Main St. Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laryngeal paralysis DUE TO (c) Carcinoma of larynx								INTERVAL BETWEEN ONSET AND DEATH 18 days 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 'o m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1967</u> to <u>Sept. 1967</u> that (I) (we) last saw the deceased alive on <u>July 11 1967</u> and that death occurred at <u>8:5 M.</u> from causes and on the date stated above.									
22a. SIGNATURE Rufus S. Gardner Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/15/67			
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER JR.				22d. ADDRESS Medical Center, Salisbury Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-18-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Virginia			
24 FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR DATE SEP 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13121

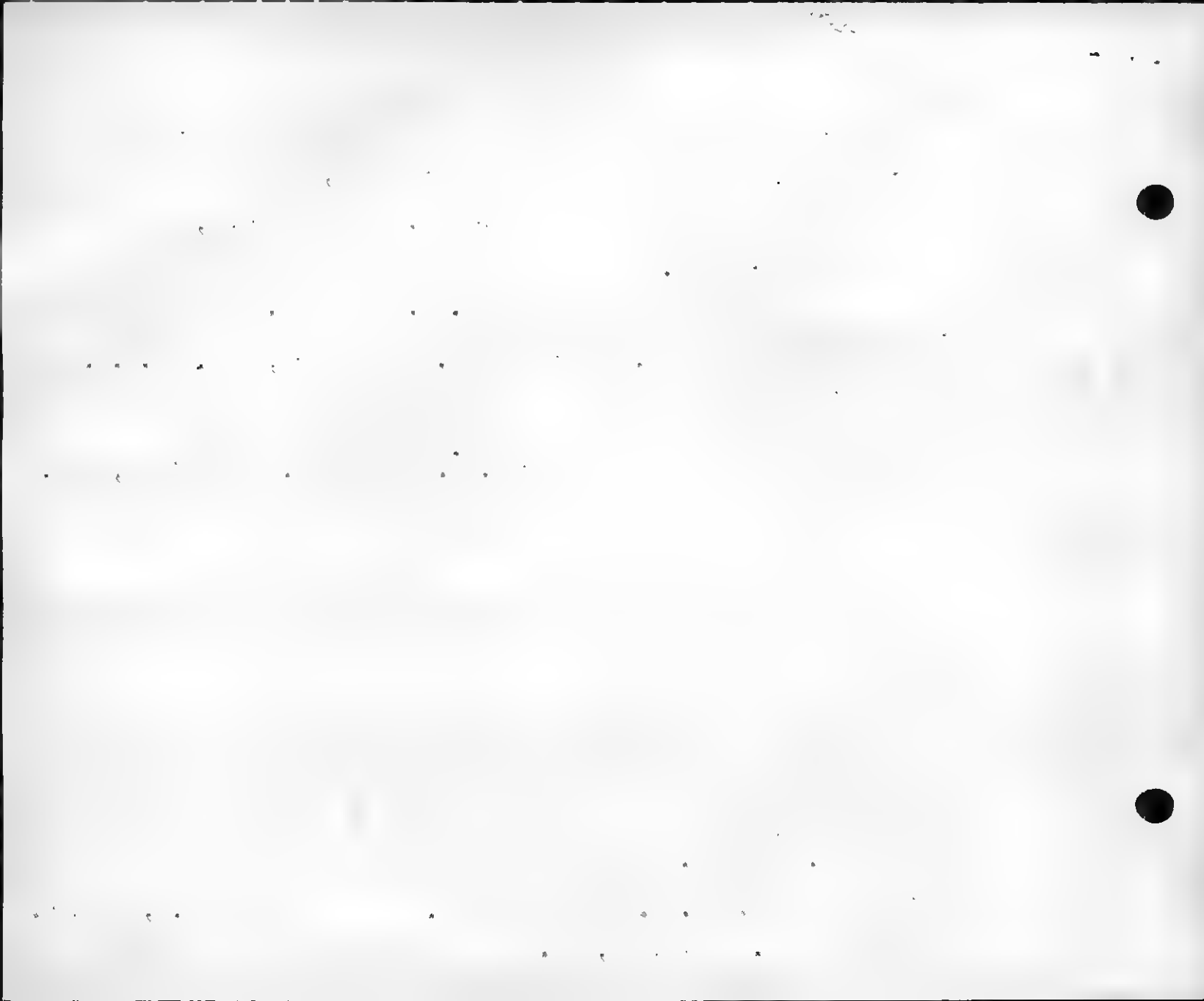
13131

1. PLACE OF DEATH a. COUNTY Wiconico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 814 e. Market Street,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles B. KNOX		4. DATE OF DEATH Month September Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2. 1895
9. AGE (In years and months) 72 yrs		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 11 Min	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months) Retired Police		10b. KIND OF BUSINESS OR INDUSTRY Del. State Police. Harrington, Del.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Knox		14. MOTHER'S MAIDEN NAME Martha Sapp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Flora Knox (Wife)		Address 814 E. Market St. Georgetown, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia with hemorrhagic diathesis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-26-1967 , to 9-16-1967 that (I) (we) last saw the deceased alive on 9-16-1967 , and that death occurred at 7:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE James L. Clafford		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) Dr. James L. Clafford		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Sept. 19. 67	23c. NAME OF CEMETERY OR CREMATORY Hollywood Cem.	23d. LOCATION (City or Town) (County) (State) Harrington. Delaware.
24. FUNERAL DIRECTOR Holloway & Co. Salisbury, Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cordon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRMOUNT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WICOMICO NURSING HOME		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM KRAMER		4. DATE OF DEATH SEPT. 16, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 11, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY 	9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NOTKNOW		14. MOTHER'S MAIDEN NAME WELFARE OFFICE PRINCESS ANNE, MD.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 	
17. INFORMANT WELFARE OFFICE PRINCESS ANNE, MD.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4252 DUE TO degenerative heart disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 7 wks. yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hodgkins disease - Prev. tuberculosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/26/67 to 9/16/67 , that (I) (we) last saw the deceased alive on 9/15/67 , and that death occurred at 4 PM , from the causes and on the date stated above.			
22a. SIGNATURE Levin R. Wilsin		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9/19/1967	23c. NAME OF CEMETERY OR CREMATORY FAIRMOUNT CEMETERY	23d. LOCATION (City, town or county) (State) FAIRMOUNT, MD.
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.		25a. REC'D BY REGISTRAR SEP 22 1967	
25b. REGISTRAR'S SIGNATURE Levin R. Wilsin			



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2 infor, taken from birth cert.

CERTIFICATE OF DEATH

13133

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury Quantico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Phillip Lee LAWRENCE		4 DATE OF DEATH Month Day Year SEPTEMBER 4 1967	
5 SEX MALE	6 COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/67
9 AGE (In years last birthday) 8		10. IF UNDER 1 YEAR Months Days Hours Min. 8 13 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillip Johnson		14. MOTHER'S MAIDEN NAME Carolyn Lawrence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Phillip Johnson		Address Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Breech birth			INTERVAL BETWEEN ONSET AND DEATH 8 hrs 13 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/4 , 1967, to 9/4 , 1967, that (I) (we) last saw the deceased alive on 9/4 , 1967, and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE DS Anderson		22b. DATE SIGNED 9/4/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/7/67	23c. NAME OF CEMETERY OR CREMATORY Quantico Cemetery	23d. LOCATION (City or Town) (County) (State) Quantico Wicomico Md.
24. FUNERAL DIRECTOR Clinton F. Stewart		25a. REC'D BY REGISTRAR SEP 13 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12150

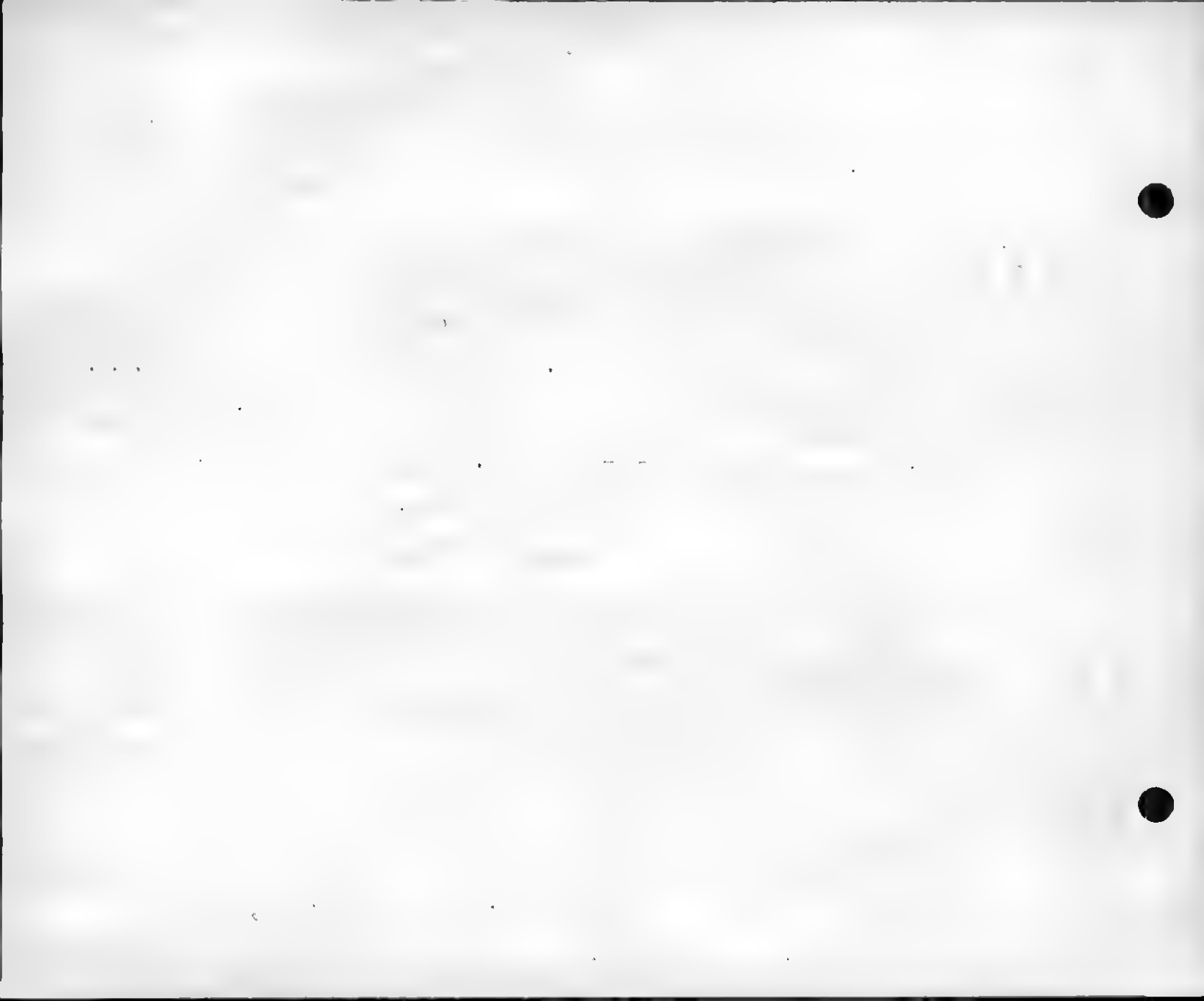
CERTIFICATE OF DEATH

13134

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 10 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 609 Oak Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linwood MARION LeCates		4. DATE OF DEATH September 15 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1924
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Box Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Marion Isaac Lecates	
14. MOTHER'S MAIDEN NAME Irma Blanche Cantwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) WW II	
16. SOCIAL SECURITY NO. 218-16-6206		17. INFORMANT Mrs. Elizabeth Lecates see #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Renal failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intestinal obstruction DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 11:45 M, from causes and on the date stated above.			
22a. SIGNATURE Nabil F. Warsal M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NABIL F. WARSAL		22d. ADDRESS Peninsula Gen. Hosp	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 9/18/1967	
23c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery		23d. LOCATION (City or Town) (County) (State) Siloam, Maryland	
24. FUNERAL DIRECTOR Hill Funeral Home		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Salisbury, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13131

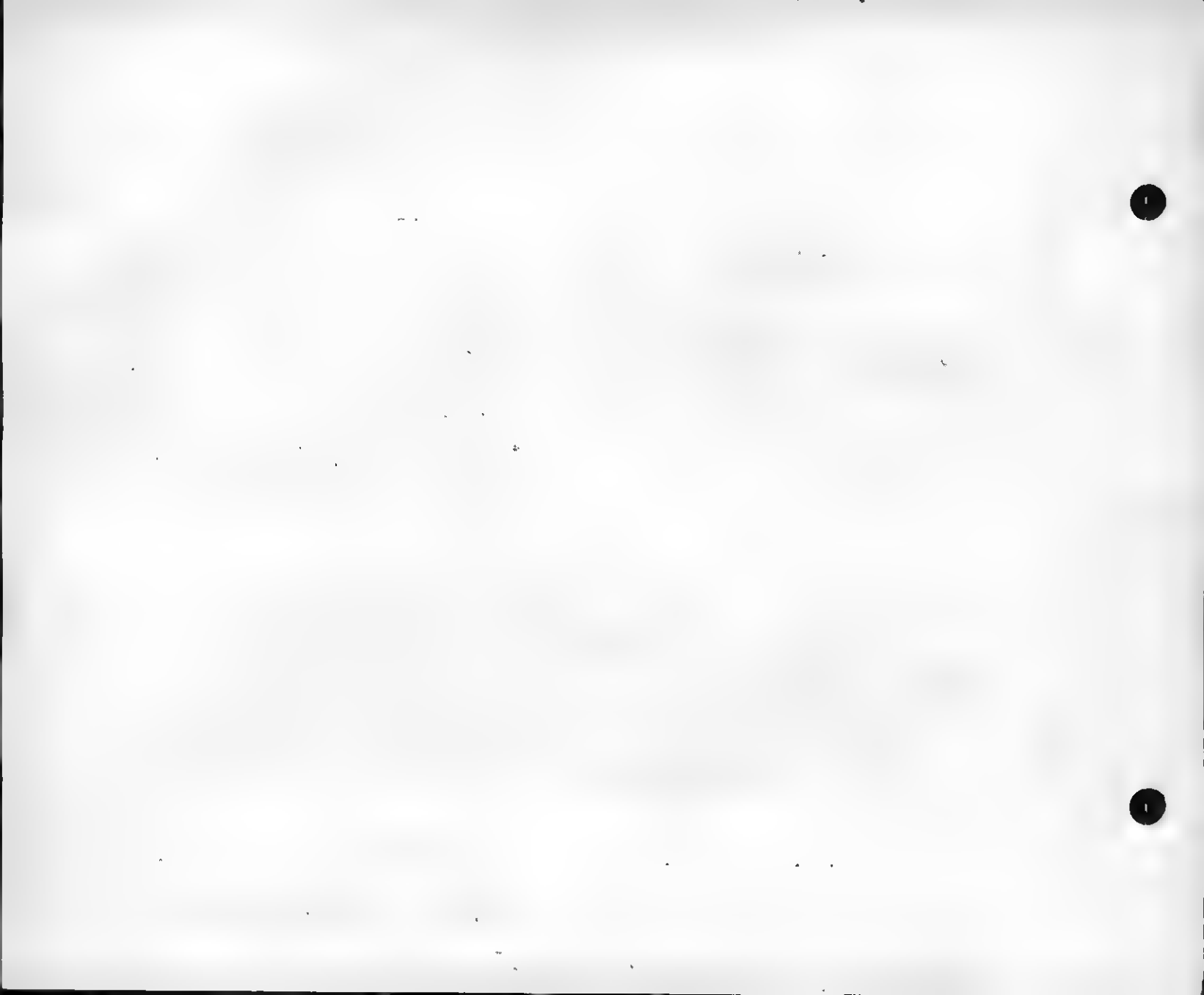
13135

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 11 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS --		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cleaven on First Middle Last CLEVELAND GROVER LEWIS				4. DATE OF DEATH Month 9 Day 18 Year 1967			
5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1895		9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Fauquier Co. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charlie Lewis				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT George L. Lewis Address 1810 E. Eager St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Coronary Artery Disease DUE TO (c) Generalized Atherosclerosis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH 11 hours years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 7, 1967 , to September 18, 1967 , that (I) (we) last saw the deceased alive on September 18, 1967 , and that death occurred at 4 A M, from causes and on the date stated above.							
22a. SIGNATURE <i>C. H. Winnacott</i>				22b. DATE SIGNED 9/18/67		22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.	
22d. ADDRESS Deer's Head State Hospital, Salisbury,				22e. MED. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22f. MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-21-67		23c. NAME OF CEMETERY OR CREMATORY St. Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR Randolph J. Collick				25a. REG'D BY REGISTRAR SEP 26 1967		25b. REG. STAFF'S SIGNATURE <i>Charles J. ...</i>	

TO HOSPITAL ■ ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

A-2-1-1-1-1
10/18/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

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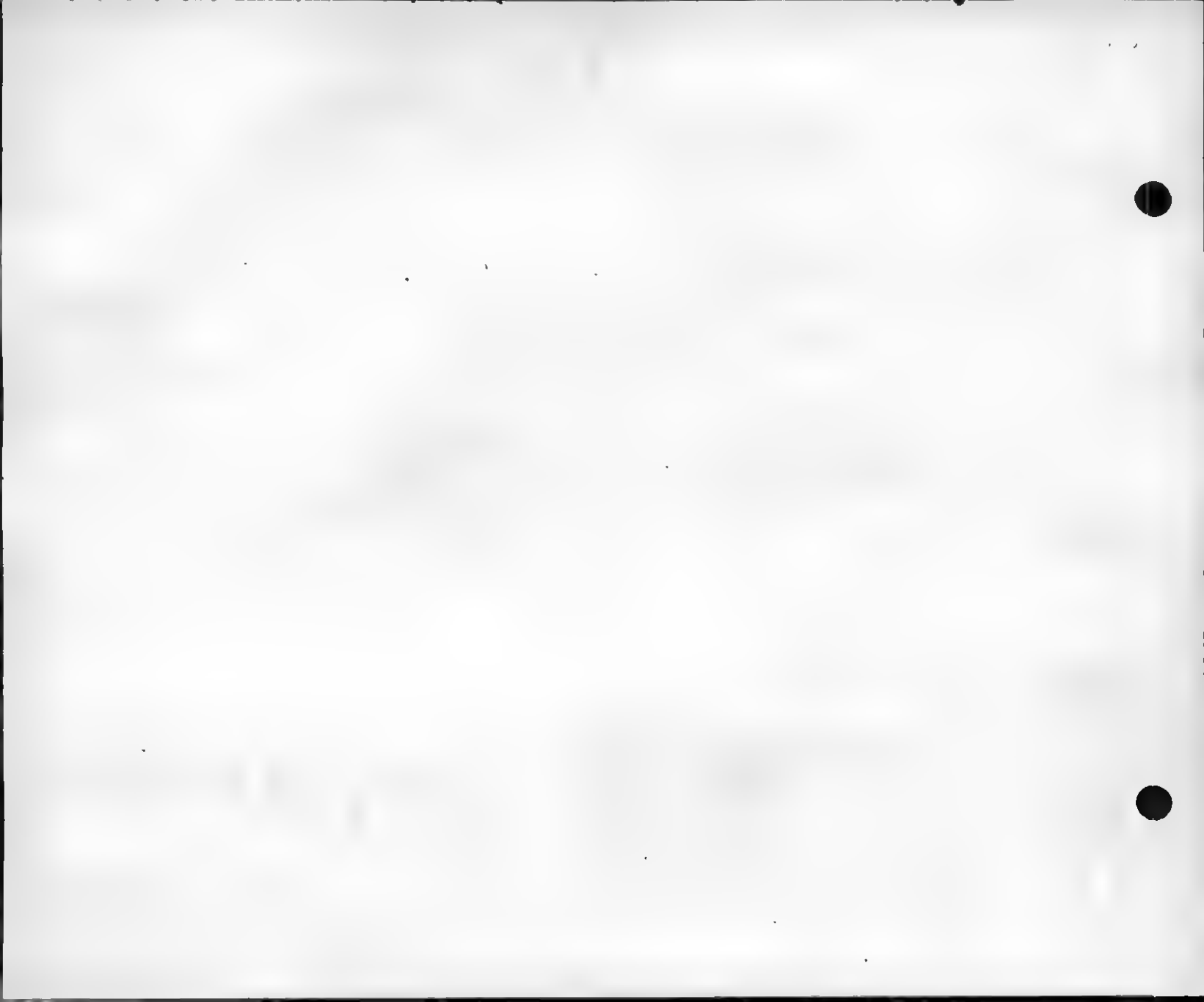
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13132

CERTIFICATE OF DEATH

13136

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 620 Liberty Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE CARLTON LLOYD		4. DATE OF DEATH SEPTEMBER 7 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1894
9. AGE (In years lost birthday) 72 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Thomas Lloyd		14. MOTHER'S MAIDEN NAME Sarah Jackson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War I		16. SOCIAL SECURITY NO. 220-10-9632	
17. INFORMANT Mrs. Edna J. Lloyd (Wife)		Address 620 Liberty Street, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 400 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inanition DUE TO (c) Gastric Ulcer		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/3 , 19 67 to 9/7 , 19 67 ; that (I) (we) last saw the deceased alive on 9/7 , 19 67 , and that death occurred at 3:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE W. B. Smith		22b. DATE SIGNED 9/7/67	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith		22d. ADDRESS 402 S. Division St., Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13133

13137

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury				c LENGTH OF STAY IN TOWN			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Wicomico River Market & Camden Streets				e STREET ADDRESS 519 Lincoln Avenue			
3 NAME OF DECEASED (Type or print) First Middle Last WILLARD STANFORD LONG				4 DATE OF DEATH Month Day Year September 20 1967			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH December 14, 1918	9 AGE (In years last birthday) 48 yrs	10 IF UNDER 20 Months Days Hours Min		11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason Employee Building			10b KIND OF BUSINESS OR INDUSTRY Building		11 BIRTHPLACE (State or foreign country) Somerset County, Maryland		12 CITIZENSHIP OF WHAT COUNTRY? USA
13 FATHER'S NAME William Long			14 MOTHER'S MAIDEN NAME Mary Elizabeth Ross				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II			16 SOCIAL SECURITY NO 188-10-1196		17 INFORMANT Mrs. Mary Etta Long (Wife) 519 Lincoln Ave., Salisbury, Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Drowning DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> PRIMARY <input type="checkbox"/> CONTRIBUTING			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Fatal Drowning				
20c TIME OF INJURY Month, Day, Year Hour a.m. 9 15 p.m. 1967			20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury		20f (City or town) (County) (State) Salisbury Wicomico Md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED September 22, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Sept. 23, 1967		23c NAME OF CEMETERY OR CREMATORY Beechwood Cemetery		23d LOCATION (City or town) (County) (State) Princess Anne, Maryland	
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a REC'D BY REGISTRAR DATE SEP 25 1967		25b REGISTRAR'S SIGNATURE James Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

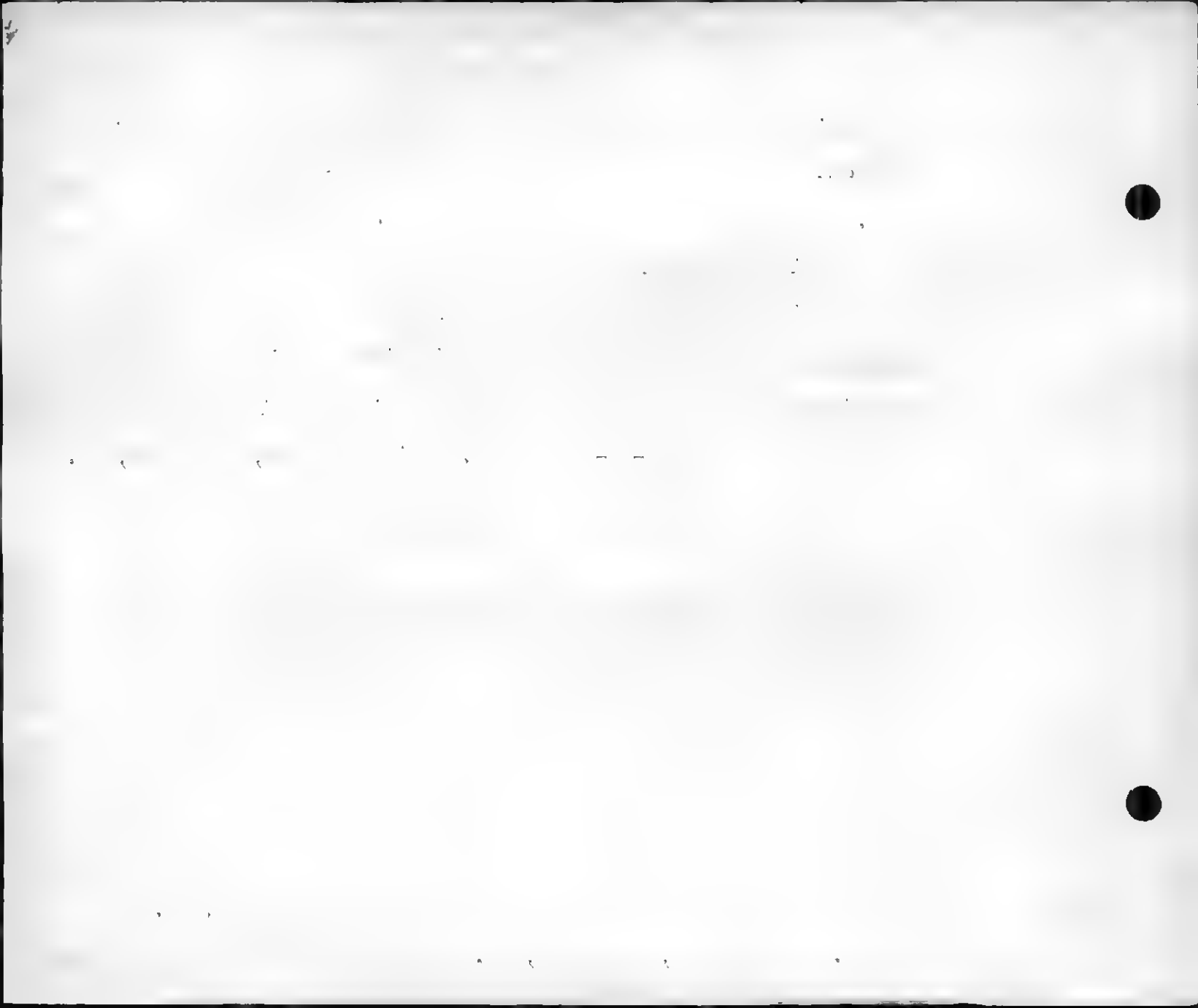
13134

13138

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> c. LENGTH OF STAY IN TB <u>10 years</u>			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> d. STREET ADDRESS <u>415 W. State Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <u>Annie Ellen Marine</u> First Middle Last			4 DATE OF DEATH <u>9/25</u> 19 <u>67</u> Month Day Year		
5. SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1882</u>	9 AGE (In years last birthday) <u>85</u> yrs	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Sussex Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Job Vincent</u>			14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Hill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>213-50-8606</u>	17. INFORMANT Address <u>Mrs. Julia Seabreeze, Sharptown, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Internal hemorrhage</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>16 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS A TOLPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 19 <u>67</u> , to <u>Sept 25</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 24</u> 19 <u>67</u> , and that death occurred at <u>7A</u> M, from causes on and on the date stated above.					
22a. SIGNATURE <u>H.S. Kuhlman</u>		22b. DATE SIGNED <u>9/26/67</u>	22c. PHYSICIAN'S NAME (Type) <u>H.S. Kuhlman</u>		
22d. ADDRESS <u>Sharptown Md</u>		22e. MED. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/27/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Taylor</u>	23d. LOCATION (City or Town) (County) (State) <u>Sharptown, Md.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>MAURICE E. NEUNAM & SON, Sharptown, Md.</u>			25a. REC'D BY REGISTRAR <u>SEP 28 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Juaze</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12130 Item #8 Film #G392 8/22/67 ph

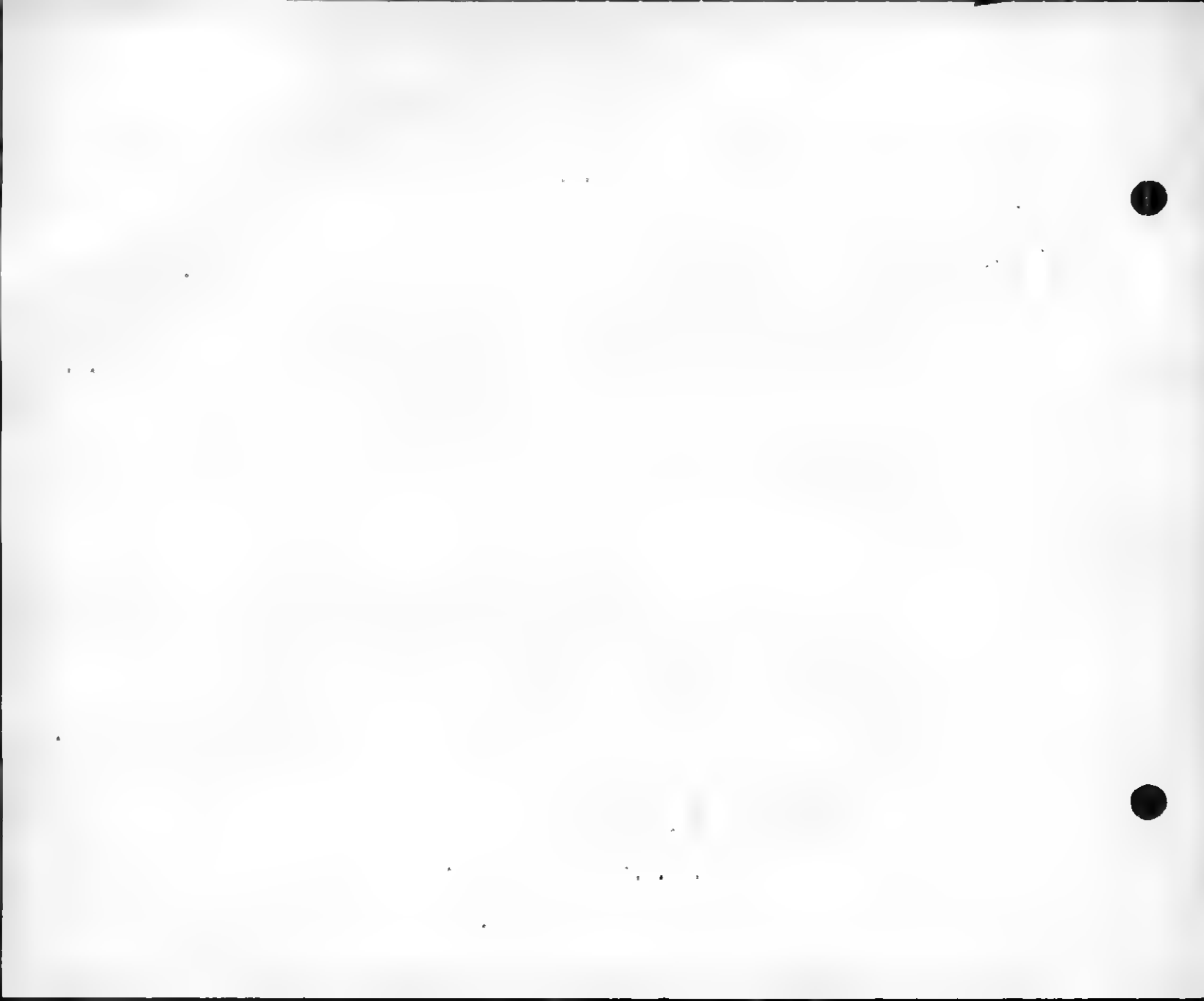
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13139

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Wicomico b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b D.O.A.		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Wicomico		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peinisula General Hospital				d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Floyd Middle Alton Last Mills		4 DATE OF DEATH Month Sept. Day 16 Year 19 67		5 SEX Male		6 COLOR OR RACE White	
7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2/26/1903/ 1906		9 AGE (In years lost birthday) 61 yrs		10 IF UNDER 1 YEAR Months 61 Days 16 Hours 19 Min 67	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b KIND OF BUSINESS OR INDUSTRY Seafood		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Isaac Mills		14 MOTHER'S MAIDEN NAME Blanche		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16 SOCIAL SECURITY NO 212-09-1734	
17 INFORMANT Viola Anderson Mills, Bivalve, Maryland		18 ADDRESS		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest (b) Crushed chest (c) Crushed chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Crushed chest		INTERVAL BETWEEN ONSET AND DEATH 1 minutes	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Lost control of auto		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month Day, Year 8:30 a.m. 9/16 19 67		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway		20f (City or town) Bivalve-Wicomico-Md. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 9/18/67		23a BURLIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 9/20/67	
23c NAME OF CEMETERY OR CREMATORY Tyaskin Com.		23d LOCATION (City or Town) Tyaskin, Maryland (County) (State)		24 FUNERAL DIRECTOR C. Messer ADDRESS Bivalve, Maryland		25a REC'D BY REGISTRAR SEP 20 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		25c CHIEF MEDICAL EXAMINER <input type="checkbox"/>		25d ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		25e DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

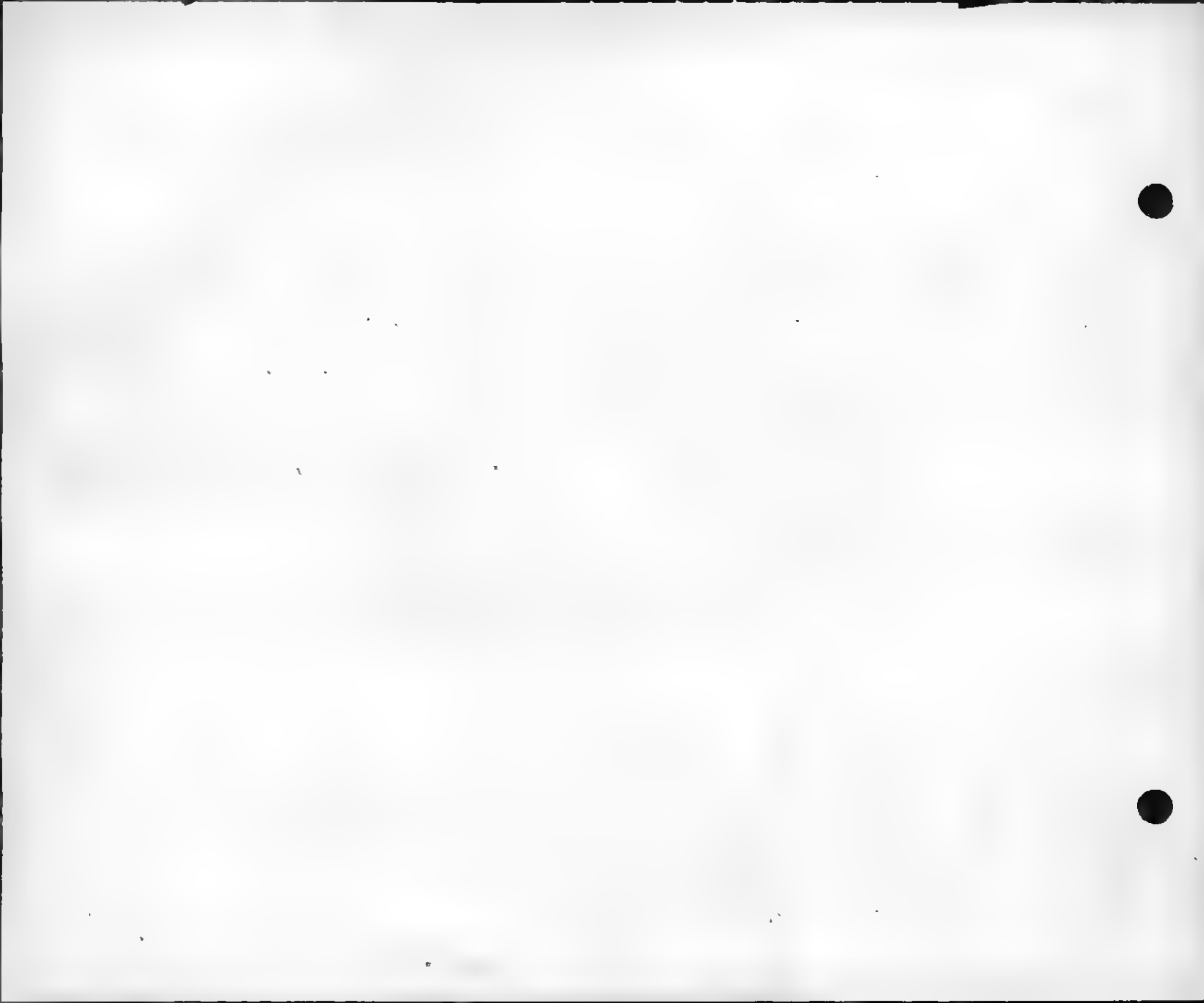
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13136

CERTIFICATE OF DEATH

13140

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Rural Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Stewart Neck Rd.	
3. NAME OF DECEASED (Type or print) First John Middle Milton Last Mohler		4. DATE OF DEATH Month September Day 19 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1897
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cher		10b. KIND OF BUSINESS OR INDUSTRY Monto Bella, Va.	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick Mohler		14. MOTHER'S MAIDEN NAME Mary Jane Fitzgerald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 123-45-6789	
17. INFORMANT Mrs. Irene Mohler, Princess Anne, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4201 DUE TO (c) 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-17, 1967 to 9-19, 1967 , that (I) (we) last saw the deceased alive on 9-17, 1967 , and that death occurred at 7:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Nevin W. Todd		22b. DATE SIGNED SEP 26 1967	
22c. PHYSICIAN'S NAME (Type) NEVIN W. TODD		22d. ADDRESS Princess Anne, Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) burial	23b. DATE THEREOF 9/22/67	23c. NAME OF CEMETERY OR CREMATORY Beechwood	23d. LOCATION (City or Town) (County) (State) Princess Anne, Somerset Md.
24. FUNERAL DIRECTOR James Hanman		25a. REC'D BY REGISTRAR SEP 26 1967	
25b. REGISTRAR'S SIGNATURE James Hanman		25c. REGISTRAR'S ADDRESS Princess Anne, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13137

CERTIFICATE OF DEATH

13141

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEAFORD (RURAL)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RD # 3 BOX 97 (WOODLAND)</u>	
3. NAME OF DECEASED (Type or print) <u>Nobel T. TALMAGE Morgan</u>		4. DATE OF DEATH <u>September 5 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 12, 1888</u>
9. AGE (in years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>	
11. BIRTHPLACE (County & State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE W. MORGAN</u>		14. MOTHER'S MAIDEN NAME <u>MARY E. NOBLE MORGAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>EVA EASON MORGAN - SEAFORD, DELAWARE</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA A LUNG</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>CWFEAS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/10</u> , 19 <u>67</u> to <u>9/5</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9/5</u> , 19 <u>67</u> , and that death occurred at <u>5:45</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>JOHN M. BLOXOM</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM</u>		22d. ADDRESS <u>MEDICAL CENT. SALISBURY, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>SEPT 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BLADES CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SEAFORD (BLADES) DEL.</u>
24. FUNERAL DIRECTOR <u>Raymond M. Watson - SEAFORD, DEL.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 11 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

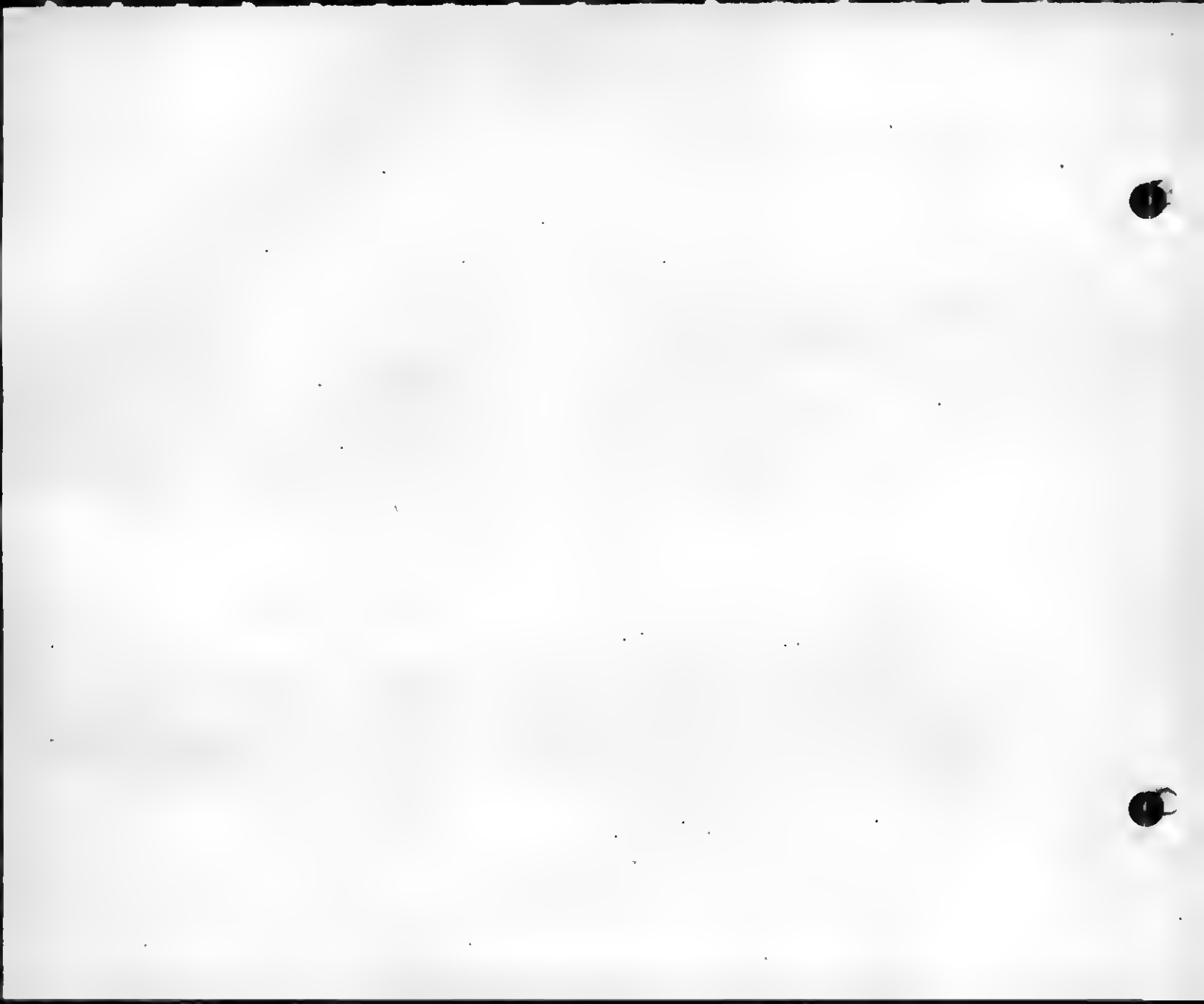


1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seebeyville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Church</u>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>ALLEN</u> Last <u>Murray</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3, 1961</u>
9. AGE (In years last birthday) <u>5 yrs.</u>		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen W. Murray</u>		14. MOTHER'S MAIDEN NAME <u>Keith Ann Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Allen W. Murray</u>		Address <u>Seebeyville, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull & cerebral hemorrhage</u> 8354 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fract. Rt. femur + fibula</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY Hour <u>9:15</u> a.m. Month, Day, Year <u>9-2-1967</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT 113 + RT 56</u>		20f. (City or town) (County) (State) <u>Waverly Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		22. DATE SIGNED <u>9-2-67</u>	
EXAMINER'S NAME (Type) <u>Ph. A. Insley</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u></u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Red man's</u>		23d. LOCATION (City, town or county) (State) <u>Seebeyville Del.</u>	
24. FUNERAL DIRECTOR <u>Richard T. Watson</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>	
ADDRESS <u>Seebeyville, Del.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

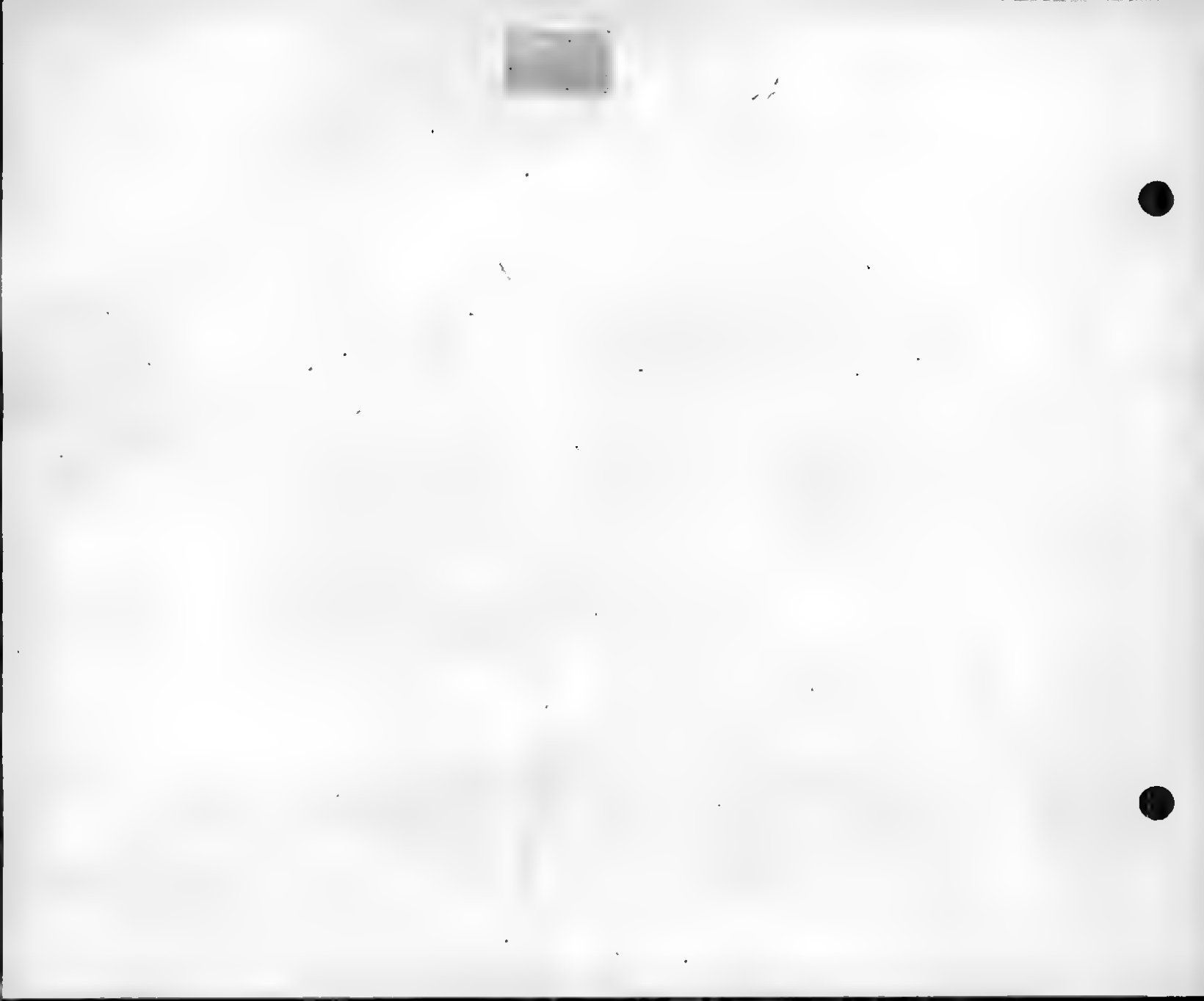
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13135

13143

1. PLACE OF DEATH a. COUNTY <u>Wiconico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 'b' <u>2 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WENONA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>MAIN ROAD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tennie M. Parker</u> First Middle Last				4. DATE OF DEATH <u>September 17</u> 19 <u>67</u> Month Day Year			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 15-</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD WORKER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN JOHNSON</u>			14. MOTHER'S MAIDEN NAME <u>MARY JOHNSON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN.</u>		17. INFORMANT <u>TRESSIE DAVIS - WENONA 2187 MD</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ATRIAL FIBRILLATION</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DIS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS GANGRENE OES. AMPUTATION</u>							19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:15</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>I. Frank Hartman II</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>I. FRANK HARTMAN II</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-20-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>JOHN WESLEY CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>DEAL ISLAND, SOM. MD.</u>	
24. FUNERAL DIRECTOR <u>Leroy Webster</u>				25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13144

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>Worcester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c LENGTH OF STAY IN 1b <u>Berlin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>R. D. TAYLORVILLE</u>	
3 NAME OF DECEASED (Type or print) First <u>Preston</u> Middle <u>William</u> Last <u>Parsons</u>		4 DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Dec. 3, 1914</u>
9 AGE (in years last birthday) <u>52</u> yrs		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISTRIBUTOR</u>		10b KIND OF BUSINESS OR INDUSTRY <u>HEATING OIL</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Berlin, MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>GEORGE PARSONS</u>		14 MOTHER'S MAIDEN NAME <u>OLIVIA MITCHELL</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>414-36-6145</u>	
17 INFORMANT <u>Mrs. Preston Parsons</u>		Address <u>Berlin, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>Stroke</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19 WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 10, 1967</u> to <u>Sept 13, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 13, 1967</u> , and that death occurred at <u>10:00</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Stamps</u>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <u>Stamps</u>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9/20/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE</u>	23d LOCATION (City or Town) (County) (State) <u>Berlin Wor MD</u>
24 FUNERAL DIRECTOR <u>Anna A. Bumbaye</u>		25a REC'D BY REGISTRAR <u>SEP 25 1967</u>	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13145

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Rt. # 1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy PETERMAN</u>		4. DATE OF DEATH <u>SEPTEMBER 15</u> 19 <u>67</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 13, 1967</u>
9. AGE (In years last birthday) <u>2</u> yrs		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XX</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>XX</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thurman Peterman</u>		14. MOTHER'S MAIDEN NAME <u>Nancy West</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u> (If yes give war or dates of service) <u>XX</u>		16. SOCIAL SECURITY NO <u>XX</u>	
17. INFORMANT <u>Nancy Peterman Mardela, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <u>7605</u> IMMEDIATE CAUSE (a) <u>Intracranial Bleeding</u> DUE TO <u>Prematurity (1219 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Due to</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Outside unattended delivery</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/13</u> , 19 <u>67</u> , to <u>9/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Alfred C. Kolls</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>9/15/67</u>
22c. PHYSICIAN'S NAME (Type) <u>ALFRED C. KOLLS</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REBURY <u>REBURY</u>	23b. DATE THEREOF <u>9/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Hebron Maryland</u>
24. FUNERAL DIRECTOR <u>Peter Mahaly Salisbury, Del.</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

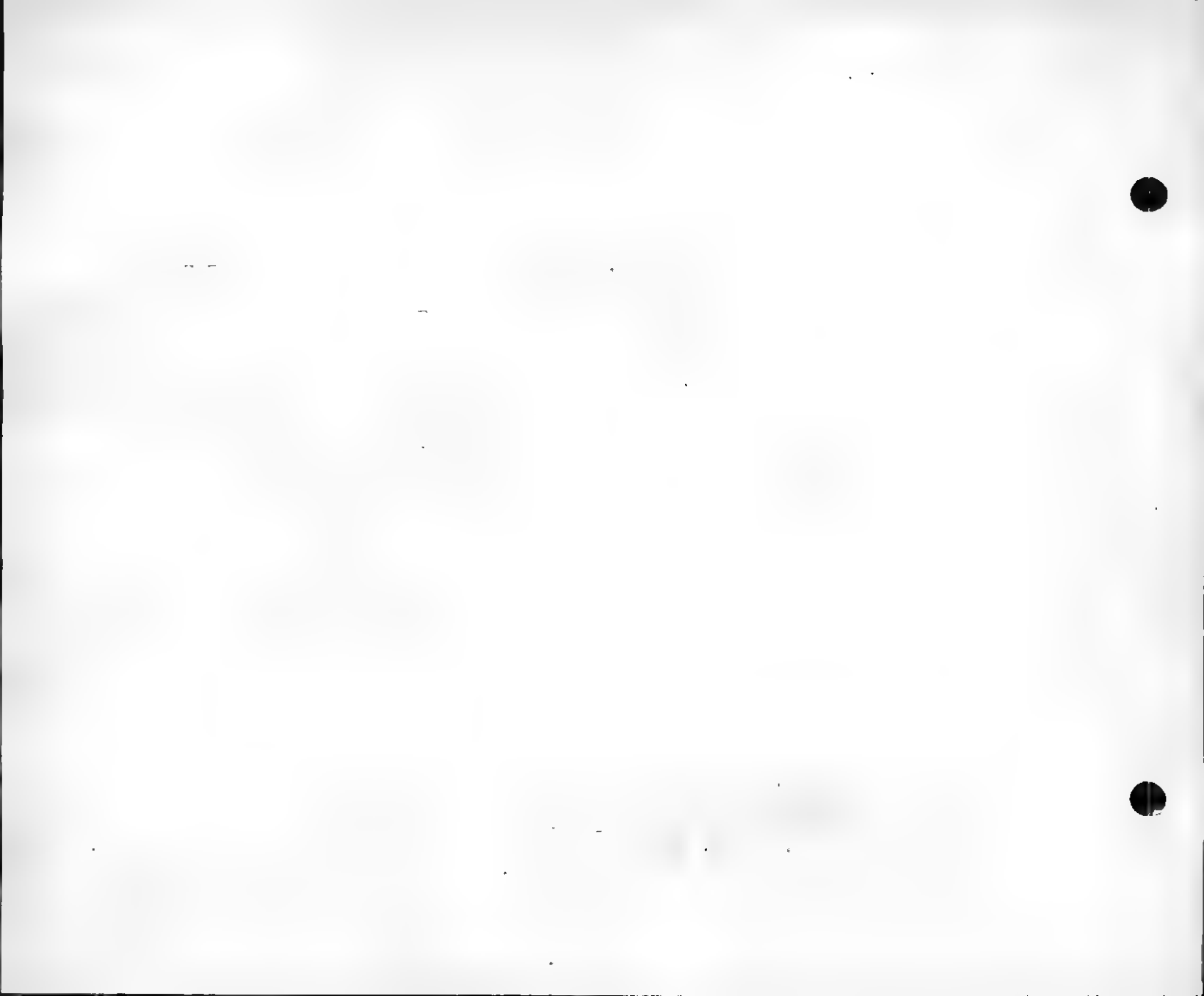
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>RFD</u>		d STREET ADDRESS <u>RFD</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>GARNER G. POLK</u>		4 DATE OF DEATH Month Day Year <u>9-7-67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>AA</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-20-09</u>
9 AGE (In years and birthday) <u>58</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Farmer</u>	
10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY <u>U.S.</u>		13 FATHER'S NAME <u>James K. Polk</u>	
14 MOTHER'S MAIDEN NAME <u>Mary Wainwright</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W.W.II</u>	
16 SOCIAL SECURITY NO <u>219-05-3344</u>		17 INFORMANT <u>Roscoe Lee Polk, Tyaskin, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage, spontaneous</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>351X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> <u>109 Camden Ave., Salisbury, Md.</u>		22. DATE SIGNED September 8, 1967	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/10/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Family Cem.</u>		23d LOCATION (City or town) (County) (State) <u>Tyaskin, Wicomico, Md.</u>	
24 FUNERAL DIRECTOR <u>Messick Funeral Home, Bivalve, Md.</u>		25a RECD BY REGISTRAR DATE <u>SEP 13 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

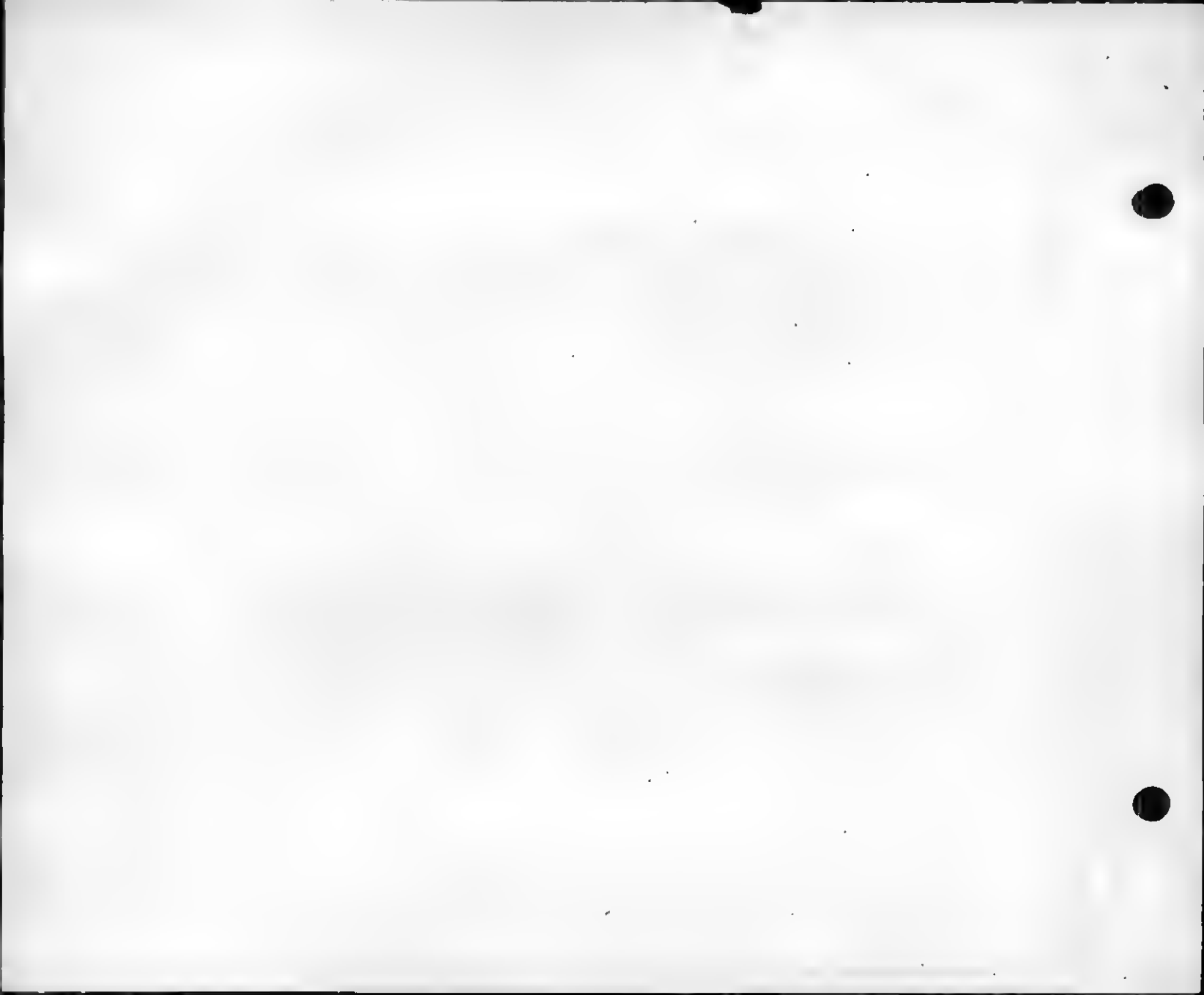
13146

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #17 Film #3-51 9/28/57 ph

CERTIFICATE OF DEATH

13147

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. STREET ADDRESS 929 E. Church Street			
3. NAME OF DECEASED (Type or print) First Middle Last EARL LEROY Prout				4. DATE OF DEATH Month Day Year September 19 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1894	9. AGE (In years last birthday) 72 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Vacuum Equip. Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lee Prout				14. MOTHER'S MAIDEN NAME Elizabeth Pardoe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-1374		17. INFORMANT (Name and Address) Mrs. Ada May Prout (Wife) 929 E. Church Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 Acute Anterior Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Obstructive Airway Disease (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 1 day Yes Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1967 to Sept 1967 , that (I) (we) last saw the deceased alive on Sept 19 1967 , and that death occurred at 7:35 M, from causes and on the date stated above.							
22a. SIGNATURE Rufus S. Gardner, Jr. M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, JR.				22d. ADDRESS MEDICAL CENTER, SALISBURY, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 22, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR SEP 21 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



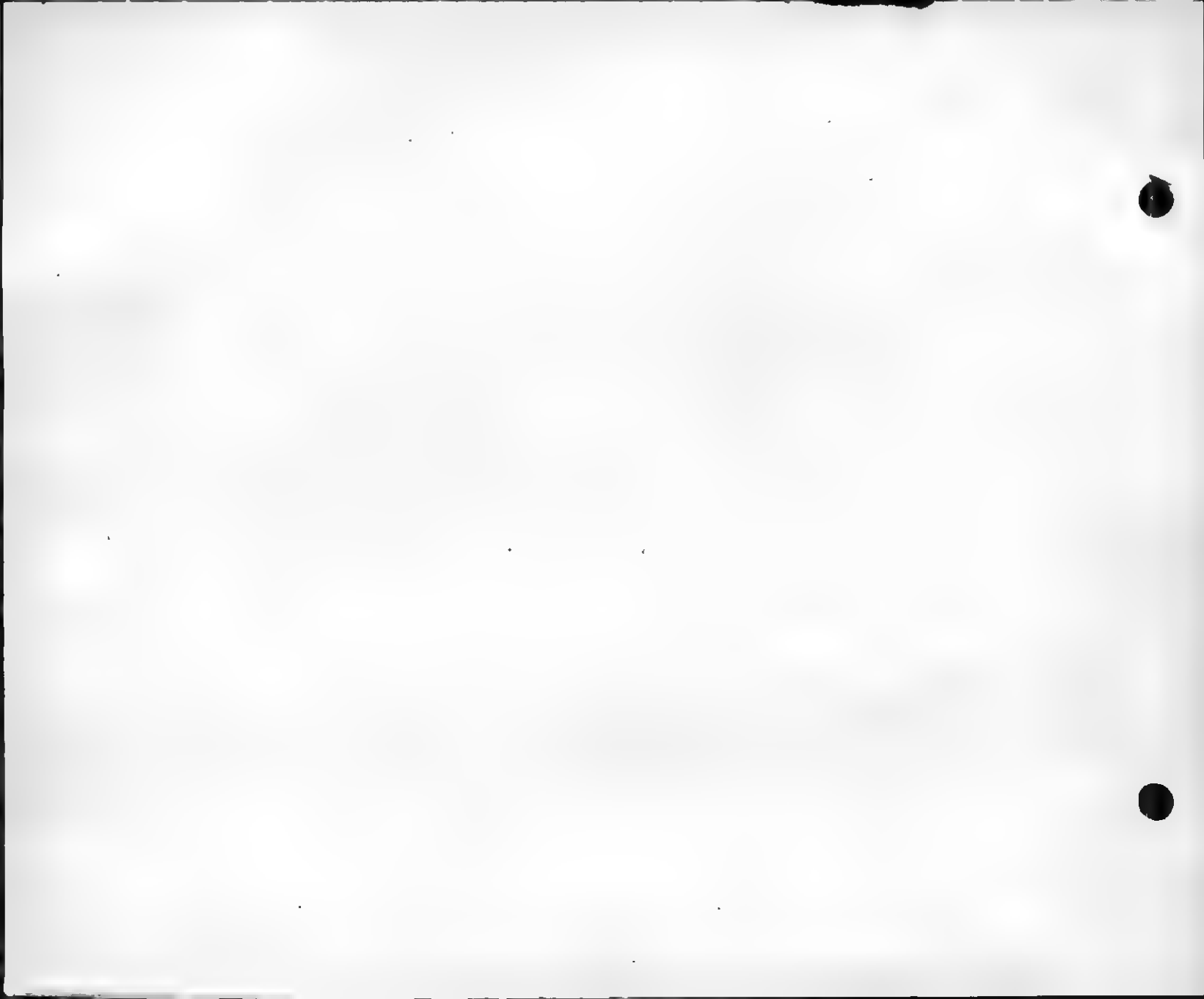
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (10)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if installed on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>18 Plover Road</u>	
3. NAME OF DECEASED (Type or print) <u>Catherine</u> First <u>RIDER</u> Last		4 DATE OF DEATH <u>SEPTEMBER 18</u> 19 <u>67</u> Month Day Year	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>NEGRO</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 7-1922</u>
9 AGE (In years last birthday) <u>45</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>PRINCESS ANNE</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>NORMAN COTTMAN</u>		14. MOTHER'S MAIDEN NAME <u>LULA POLK</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>220-01-1267</u>	
17. INFORMANT <u>BENJAMIN RIDER</u>		Address <u>18 Plover Rd Salis.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> DUE TO (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>8 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-14</u> , 19 <u>67</u> , to <u>9-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>67</u> , and that death occurred at <u>4:25</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>19 Sept 67</u>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>9-24-67</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Mary's Baptist</u>	23d LOCATION (City or Town) (County) (State) <u>West Post Off. cc Som. Md.</u>
24 FUNERAL DIRECTOR <u>Luther S. Jolley</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 22 1967</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13145

13149

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Delaware b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY in tb			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d. STREET ADDRESS Route 3			
3 NAME OF DECEASED (Type or print) CLIFTON MURPHY RIDER				4 DATE OF DEATH Month 9 Day 14 Year 67			
5. SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-25-28	9 AGE (In years last birthday) 39 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY own farm			11 BIRTHPLACE (State or foreign country) Delaware		12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George H. Rider			14. MOTHER'S MAIDEN NAME Cora Ellis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220 24 3060		17. INFORMANT Irma R Rider, re Laurel, Delaware			Address
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Compound fracture of skull DUE TO (b) sudden DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of auto involved in collision with another auto.					
20c. TIME OF INJURY Month Day Year 1:52 p.m. 9-14-67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Rt. 347 & Rt. 50		20f. (City or town) (County) (State) Hebron Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/67		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem Grn.		23d. LOCATION (City or Town) (County) (State) Hebron Wicomico Md.	
24 FUNERAL DIRECTOR Windsor & Disharoon Funeral Home, Laurel, Del.				25a. REC'D BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

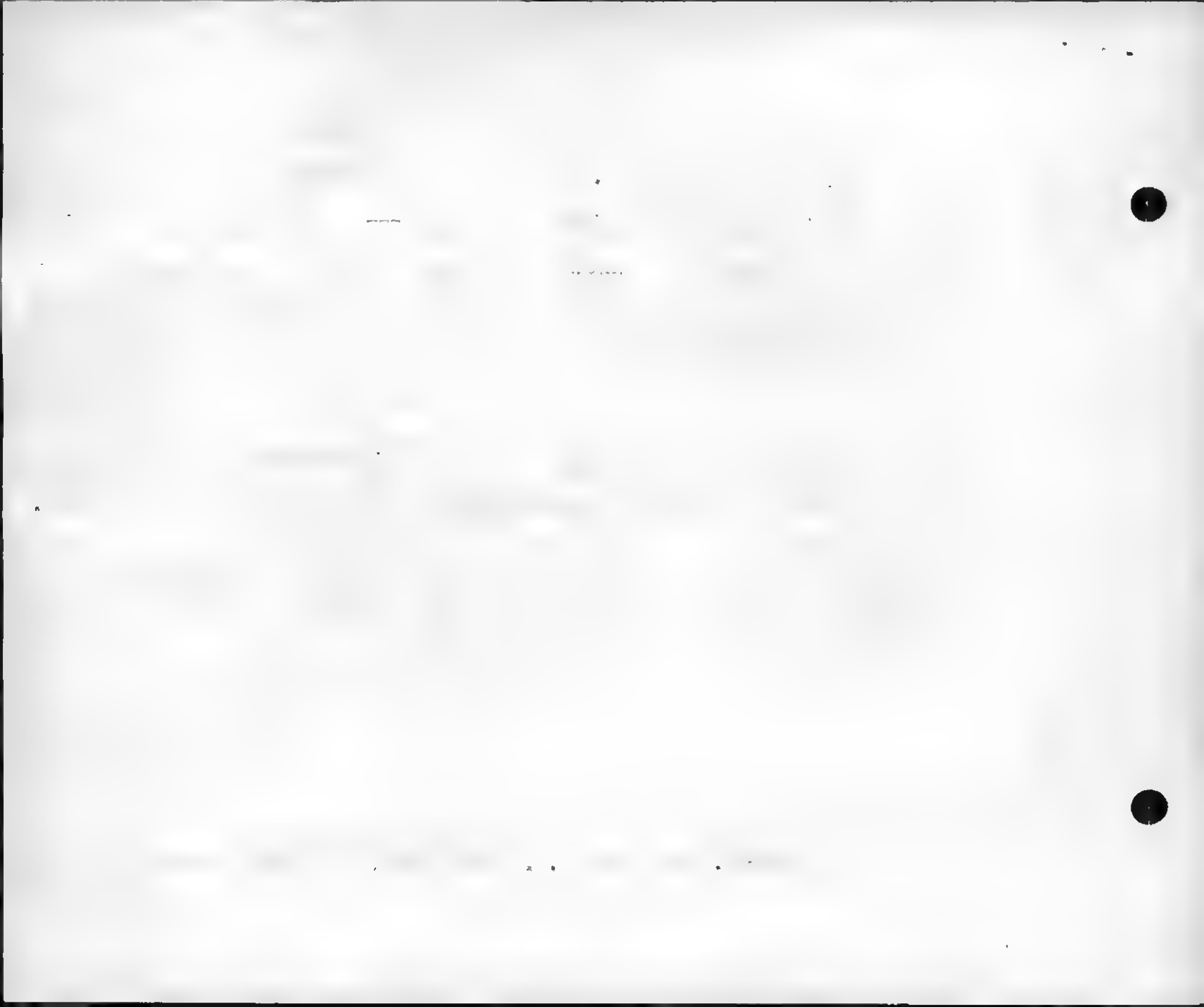
18146

CERTIFICATE OF DEATH

13150

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 Mos. 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 14	
3. NAME OF DECEASED (Type or print) First Elsie Middle P. Last Rollison		4. DATE OF DEATH Month September Day 11 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28, 1894
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (County & State, or foreign country) Northeast, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ----- Jones		14. MOTHER'S MAIDEN NAME Elizabeth ----- Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 222-05-9237	
17. INFORMANT Eleanor Stiely, 108 Cherry Lane, Hospital Records Wilmington, Del.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma (Terminal) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 19 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/10/67 , 19__ to 9/11/67 , 19__, that (I) (we) last saw the deceased alive on 9/11/67 , 19__, and that death occurred at 4:15 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott M.D.		22b. DATE SIGNED 9/11/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d. ADDRESS Deer's Head State Hospital Box 2018, Salisbury, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Lombardy Cemetery	23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25. REC'D BY REGISTRAR SEP 13 1967	
26. REGISTRAR'S SIGNATURE [Signature]		27. REGISTRAR'S SIGNATURE [Signature]	



FOR STATE
HEALTH DEPT.

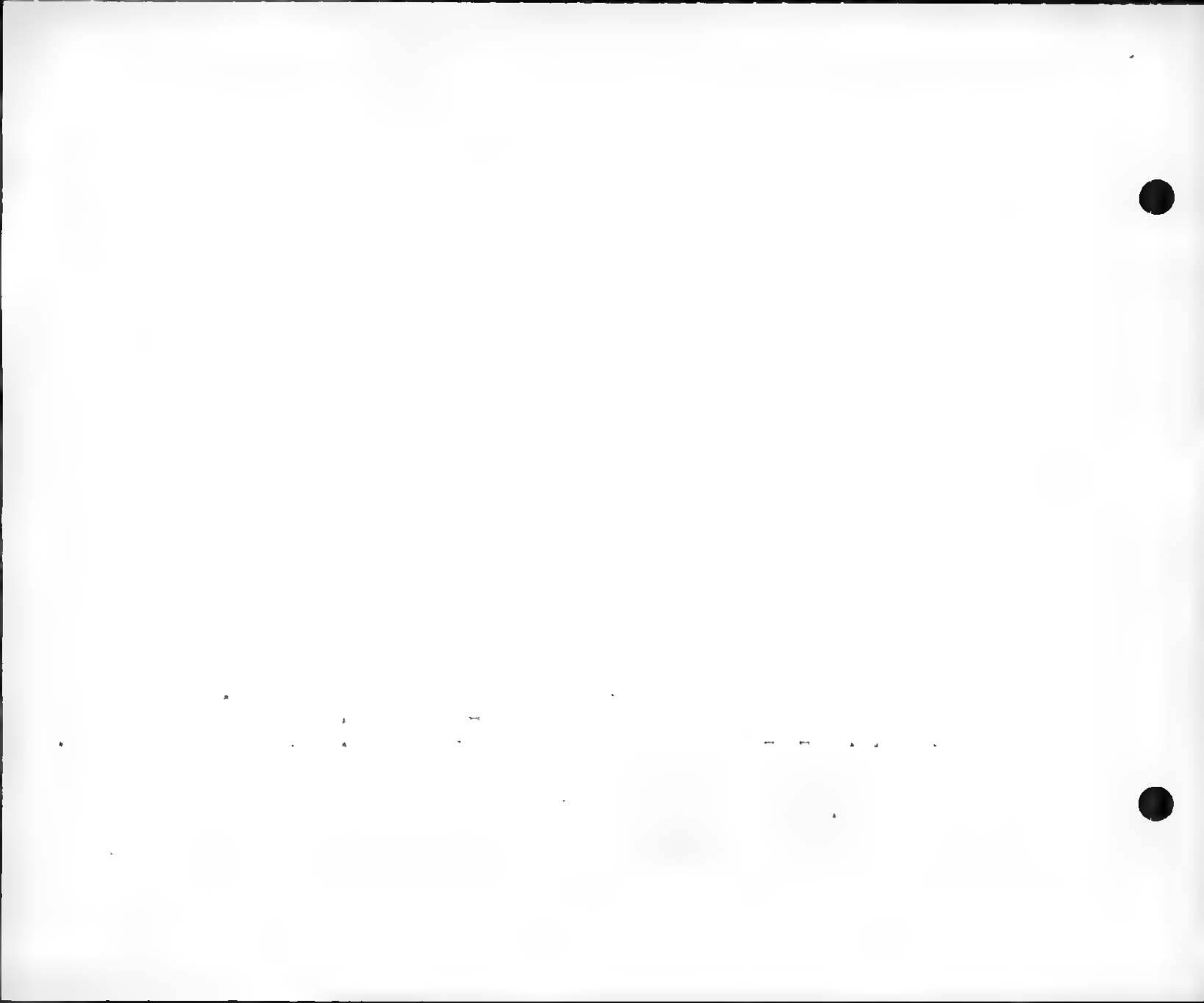
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13151

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jersey & Waller Roads		d. STREET ADDRESS R.D.#2, Hickory Mill Road	
3. NAME OF DECEASED (Type or print) JEAN RUTH ROUNDS		4. DATE OF DEATH Month September Day 29 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH October 30, 1937
9 AGE (In years last birthday) 29 yrs		10 F UNDER 1 YEAR IF UNDER 24 HRS Months 19 Days 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Key Punch Operator		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Jersey City, N. J.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Shufflebotham		14 MOTHER'S MAIDEN NAME Ruth R. Richard	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 222-24-9549	
17 INFORMANT Mr. William Theodore Rounds (Husband)		Address R.D.#2, Hickory Mill Road, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Crushed chest DUE TO (b) 10.7 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in a collision.	
20c TIME OF INJURY Month, Day, Year 6:45 P.M. 9-29-67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work Corner - Jersey Rd. Highway - Waller Rd. Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED October 2 / 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF October 3, 1967	23c NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Maryland	
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a REC'D BY REGISTRAR OCT 4 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If City, County, or State Health Department is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3, page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

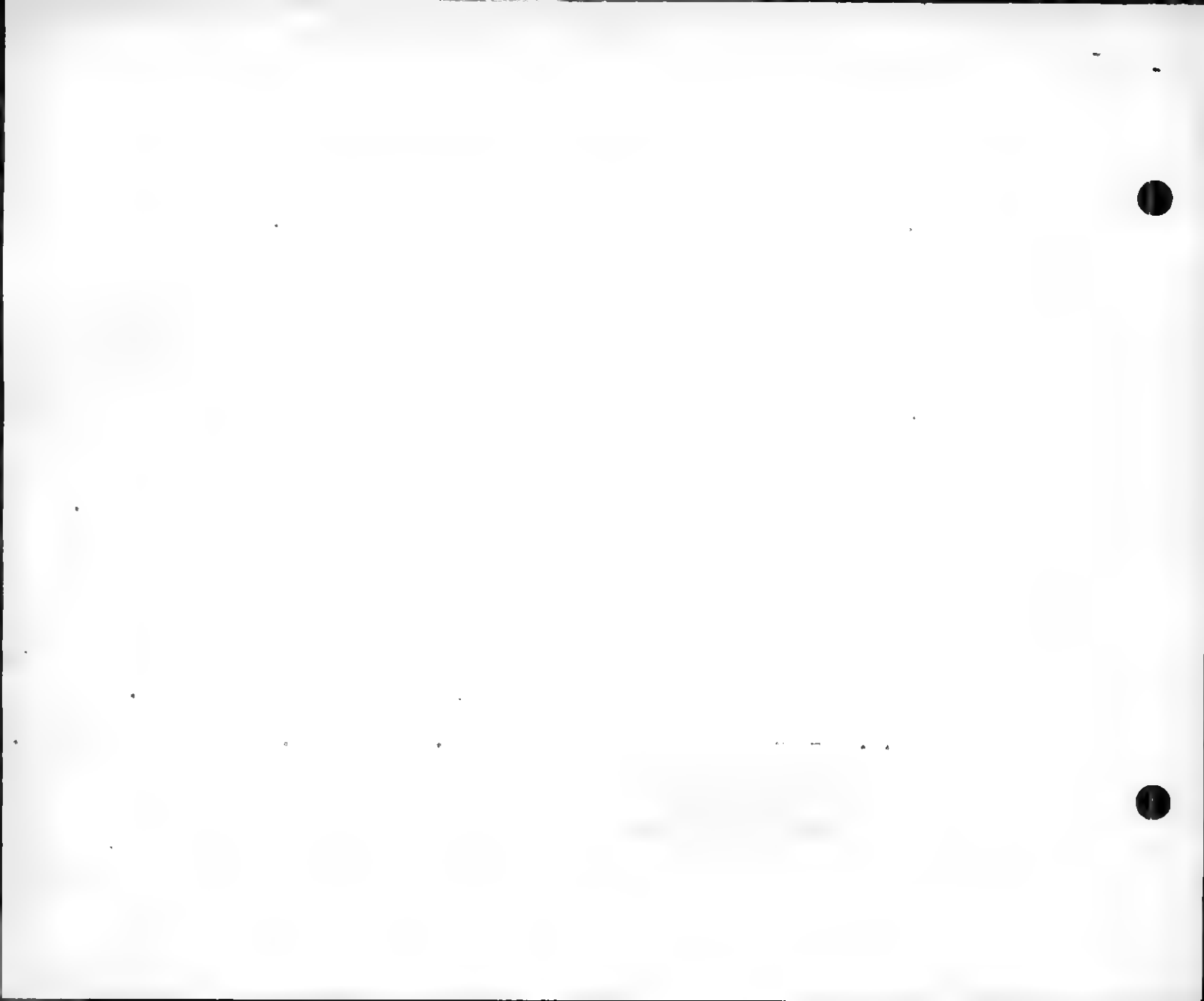
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jersey & Waller Roads		e STREET ADDRESS R.D.#2, Hickory Mill Road	
3. NAME OF DECEASED (Type or print) First SHIRLEEN Middle (NMI) Last ROUNDS		4 DATE OF DEATH Month September Day 29 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Child <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 16, 1963
9 AGE (In years lost birthday) yrs 4		10. UNDER 1 YEAR Months Days Hours Min 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (State or foreign country) Salisbury, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William Theodore Rounds		14 MOTHER'S MAIDEN NAME Jean Ruth Shufflebotham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ---	
17 INFORMANT Mr. William Theodore Rounds (Father)		Address R.D.#2, Hickory Mill Rd., Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 45 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Rear seat passenger in car involved in collision.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:45 P.M. 9-29-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Jersey Rd. at Waller Rd. Salisbury Wicomico Md.		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED October 2 / 1967	
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF October 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Maryland	23d. LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR OCT 4 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
20 M 1/68

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10143

13153

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>530 ALABAMA AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS WILSON SCARBOROUGH</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 24 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 7, 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES REP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fed. Exp. Bd. Co.</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT T. SCARBOROUGH</u>		14. MOTHER'S MAIDEN NAME <u>MARIAN BRIFFETH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>219-03-1962</u>	
17. INFORMANT <u>MRS. T.W. SCARBOROUGH</u>		Address <u>SEE 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nor While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-24, 1967</u> to <u>9-24, 1967</u> , that (I) (we) last saw the deceased alive on <u>9-24, 1967</u> , and that death occurred at <u>8:20 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Wilbur R. Ellis</u>		22b. DATE SIGNED <u>9-24-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILBUR R. ELLIS</u>		22d. ADDRESS <u>MED. CTR. SALISBURY, MD.</u>	
23a. BURIAL, CREMATION, TEMPORAL (Specify)	23b. DATE THEREOF <u>9/27/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>SALISBURY, MD.</u>
24. FUNERAL DIRECTOR <u>HILL FUN. HOME</u>		25a. REC'D BY REGISTRAR <u>SALISBURY, MD.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 27 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13150

CERTIFICATE OF DEATH

13154

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>314 GLEN AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA MARIE SCHAA</u>				4. DATE OF DEATH Month Day Year <u>SEPTEMBER 17 1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 14, 1896</u>	
9. AGE (In years last birthday) <u>71</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. SALESLADY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PENNA. PHIL CO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE PROPERT</u>				14. MOTHER'S MAIDEN NAME <u>MARIE NANCY CREDE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HERBERT S. SCHAA</u> Address <u>SEE 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA - CONVUSION</u> DUE TO (b) <u>CEREBRAL METASTASIS</u> DUE TO (c) <u>CARCINOMA COLON - LEFT</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MON'S</u> <u>2 MON'S</u> <u>12 MON'S</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>HEPATIC METASTASIS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/22, 1967</u> to <u>9/17, 1967</u> , that (I) (we) last saw the deceased alive on <u>9/17, 1967</u> , and that death occurred at <u>9:40 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>John M. Bloxom III</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/17/1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOAN M. BLOXOM III</u>				22d. ADDRESS <u>MED. CENTER, SALISBURY, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/1/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEM.</u>		23d. LOCATION (City or town) (County) (State) <u>PHILA. PENNA</u>	
24. FUNERAL DIRECTOR <u>HILL FUNERAL HOME Salisbury, MD</u>				25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12151

CERTIFICATE OF DEATH

13155

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.D. IRONS WIRE</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E</u> Last <u>SCOTT</u>				4 DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>18</u> Year <u>1967</u>			
5 SEX <u>MALE</u>	6 COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>MAY 9, 1887</u>	9 AGE (In years last birthday) <u>80</u> yrs.	10 IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11 IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSEMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11 BIRTHPLACE (Country & State, or foreign country) <u>BERLIN MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H SCOTT</u>				14 MOTHER'S MAIDEN NAME <u>ELLEN WEST</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MRS. MARGARET ROBERTS STELBYVILLE PA</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition + dehydration</u> DUE TO (b) <u>Chronic brain syndrome</u> DUE TO (c) <u>Postoperative Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>9-12-</u> 19 <u>67</u> to <u>9-18</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-18</u> 19 <u>67</u> , and that death occurred on <u>9-18</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James P. Cuyler</u>				22b. DATE SIGNED <u>9-18-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN WOA MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Birkage Berlin, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled up by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 77 hours after death.

VR A15 (4)
25M 1/67
10/19/67

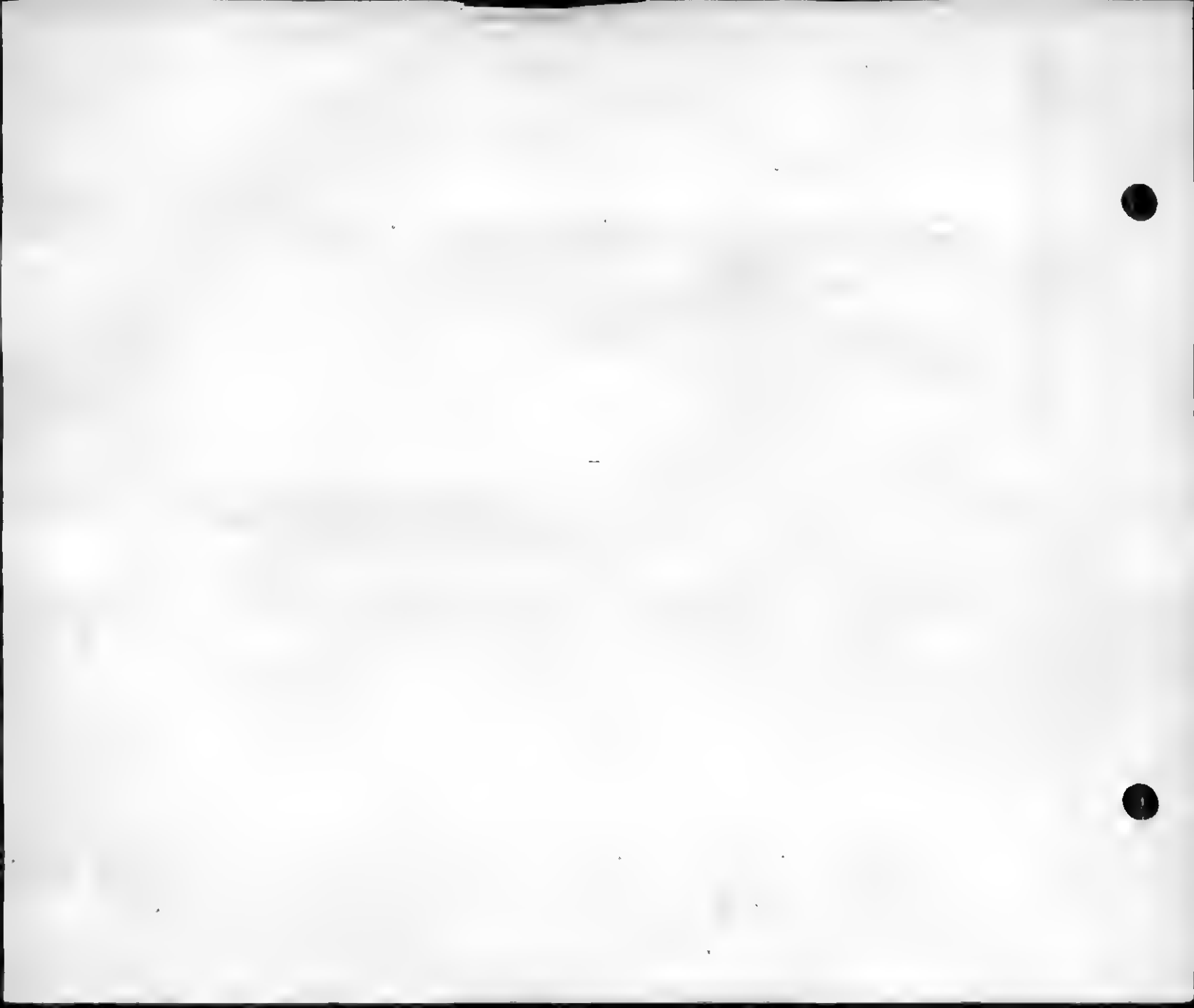
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13152

13156

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital			d. STREET ADDRESS Rt. #2, Box 260		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First EDNA Middle SCOTT Last SCOTT			4. DATE OF DEATH Month 9 Day 18 Year 19 67		
5 SEX ♀	6 COLOR OR RACE F C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/16/1903		9 AGE (in years last birthday) 64 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Spencer			14. MOTHER'S MAIDEN NAME Mary ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 219-14-3142	17 INFORMANT McGarinel Thernten Phila, Pa		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of larynx with metastasis to neck, liver and lower spine 101X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 8-9 months
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 7, 1967 , to September 18, 1967 , that (I) (we) last saw the deceased alive on September 18, 1967 , and that death occurred at 3:50 A.M. from causes and on the date stated above.					
22a. SIGNATURE L. V. Maldve		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9/23/67	23c. NAME OF CEMETERY OR CREMATORY McCarmel		23d. LOCATION (City or Town) (County) (State) Princess Anne, Md	
24 FUNERAL DIRECTOR William F James Jr.		ADDRESS Princess Anne, Md		25a REC'D BY REGISTRAR SEP 22 1967	25b REGISTRAR'S SIGNATURE Charles Judge

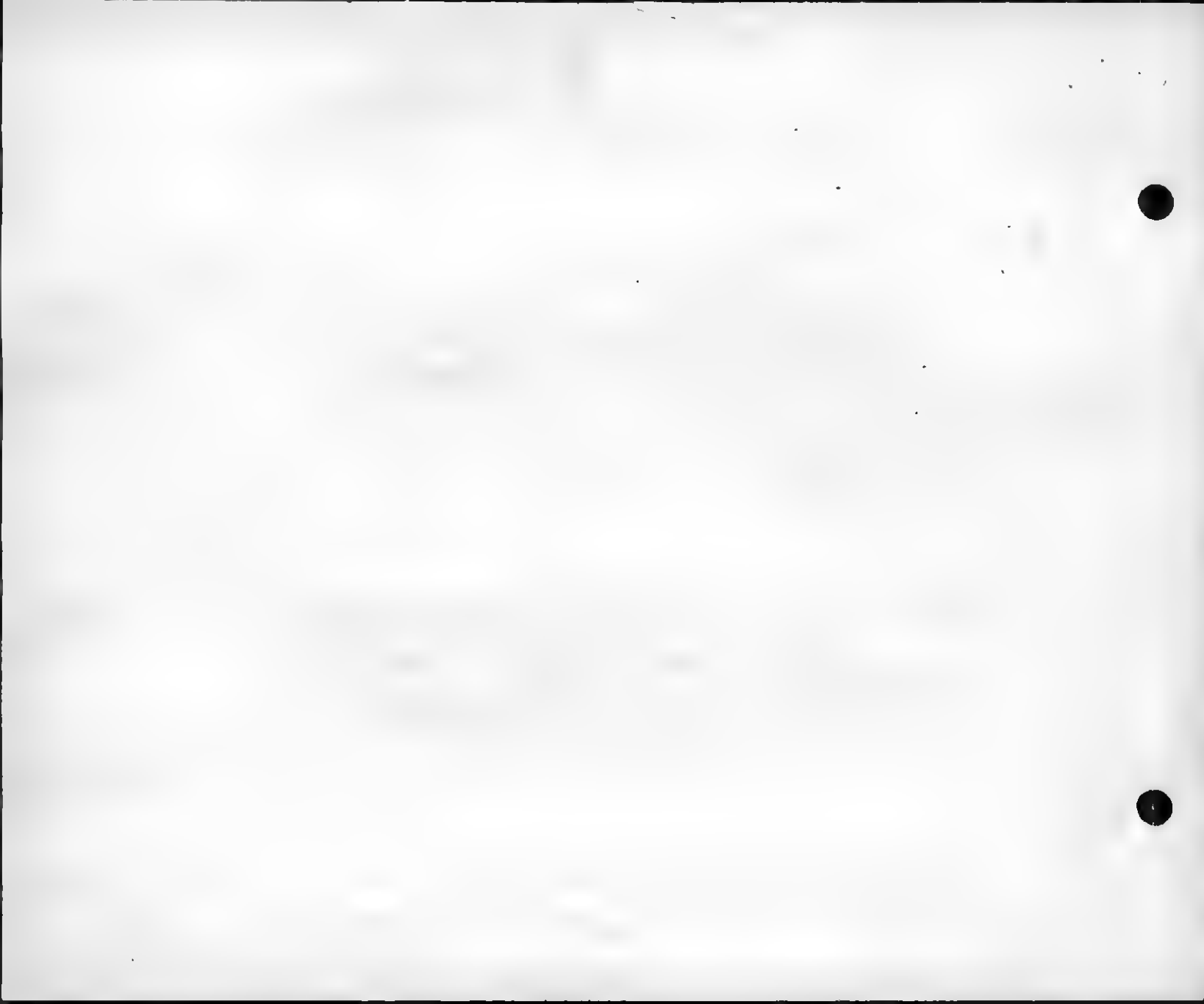


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/64

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>R.D.#2</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BEULAH</u> Middle <u>LOUISE</u> Last <u>SERMAN</u>					4. DATE OF DEATH <u>SEPTEMBER 25</u> 19 <u>67</u> Month <u>SEPTEMBER</u> Day <u>25</u> Year <u>1967</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24, 1903</u>		9. AGE (In years last birthday) <u>64</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <u>Hebron, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Ernest Marion Mills</u>					14. MOTHER'S MAIDEN NAME <u>Louise Bailey</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO <u>213-10-8355</u>		17. INFORMANT <u>Mr. Lester C. Serman (Husband)</u> <u>R.D.#2, Salisbury, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-4</u> , 19 <u>67</u> to <u>9-25</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>9-25</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> P.M., from causes and on the date stated above.									
22a. SIGNATURE <u>Wilbur R. Ellis, Jr.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-25-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis, Jr.</u>					22d. ADDRESS <u>Medical Center, Salisbury, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 27, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springhill Memory Gardens</u>			23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

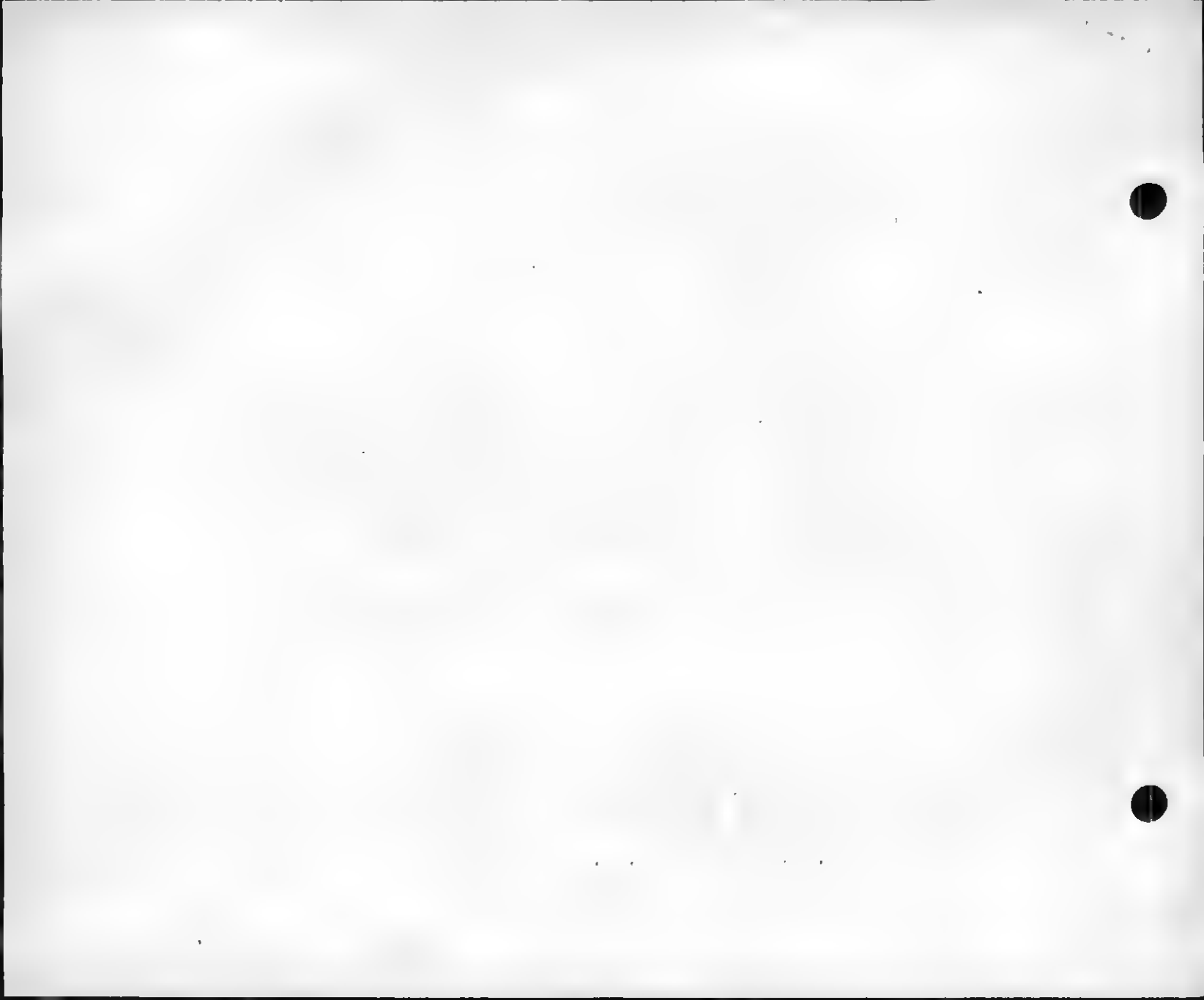
CERTIFICATE OF DEATH

13158

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>Nomreh Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Harry Shockley</u>				4. DATE OF DEATH Month Day Year <u>September 12 19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1887</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (County & State, or foreign country) <u>Accomac, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Shockley</u>				14. MOTHER'S MAIDEN NAME <u>Sereatha Lescallette</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes War I</u>		16. SOCIAL SECURITY NO <u>222-03-9348</u>		17. INFORMANT <u>Mr. W. C. Gregory (Step-son)</u> <u>R.D. #7, Nomreh Rd., Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary failure</u> + 201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition and debility</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 30</u> , 19 <u>67</u> , to <u>Sept 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 12</u> , 19 <u>67</u> , and that death occurred at <u>6:45AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>A. C. Mitchell</u>				22b. DATE SIGNED <u>9/12/67</u>		22c. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>	
22d. ADDRESS <u>Deer's Head State Hospital; Salisbury, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>SEP 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13155

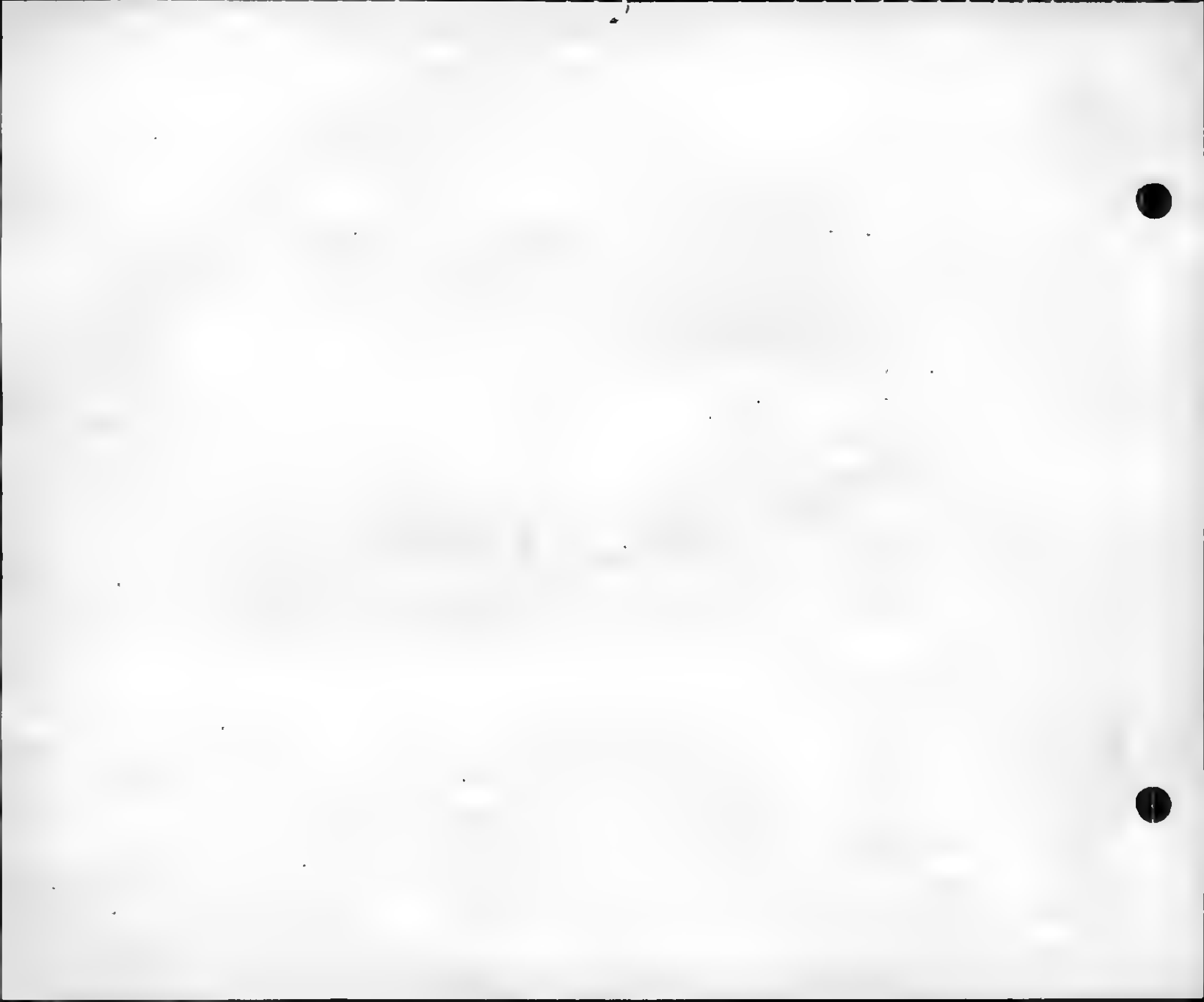
CERTIFICATE OF DEATH

13159

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Linden Ave Ext.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>P.</u> Last <u>Siddons</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 26 1891</u>
9. AGE (In Years) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Rufus Powell</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Carey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs Warren Bloodworth</u>		Address <u>Princess Anne Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Coronary Artery Disease</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/19/1967</u> to <u>9/23/1967</u> that (I) (we) last saw the deceased alive on <u>9/23/1967</u> and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dwight Burton</u>		22d. ADDRESS <u>Medical Center Salisbury Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>	23d. LOCATION (City or Town) (County) (State) <u>Princess Anne Somerset Md</u>
24. FUNERAL DIRECTOR <u>James L. Linn</u>		25a. REC'D BY REGISTRAR <u>SEP 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rewrap carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

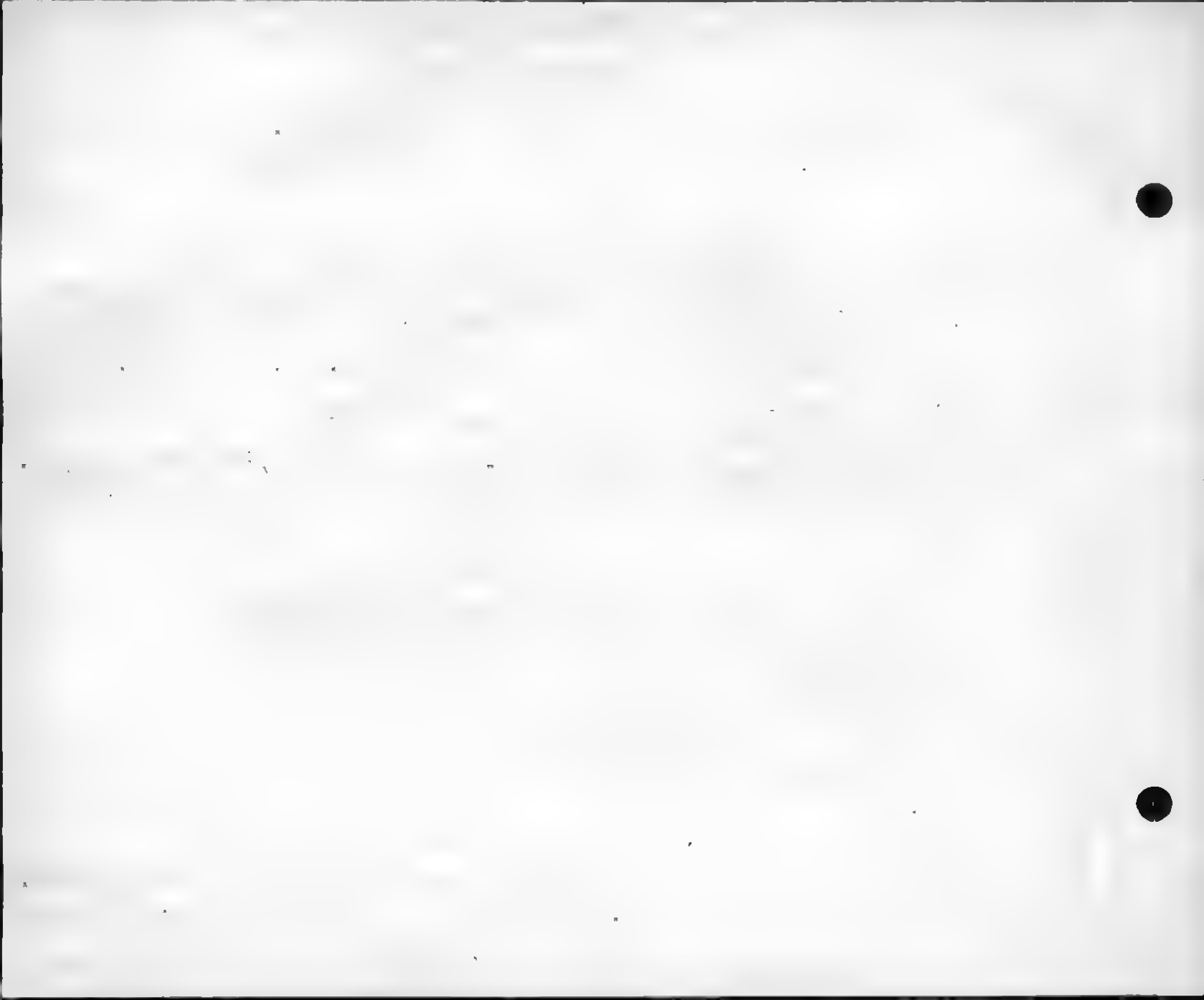
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13150

CERTIFICATE OF DEATH

13160

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Somerset Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS RFD #3	
3. NAME OF DECEASED (Type or print) ERNEST Mace SMITH		4. DATE OF DEATH SEPTEMBER 6 1967	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1888
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Produce Buyer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edward Smith		14. MOTHER'S MAIDEN NAME Elizabeth Windsor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ann Smith, RFD#3, Princess Anne, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis, advanced		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 31, 1967 to Sept 6, 1967 , that (I) (we) last saw the deceased alive on Sept 6, 1967 , and that death occurred at 11:30 M., from causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID J. GILMORE		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/67	
23c. NAME OF CEMETERY OR CREMATORY St. Andrews		23d. LOCATION (City or Town) (County) (State) Princess Anne, Somerset Md.	
24. FUNERAL DIRECTOR James L. Harmon		25a. REC'D BY REGISTRAR SEP 13 1967	
ADDRESS Princess Anne, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Eden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Eden</u>	
3. NAME OF DECEASED (Type or print) <u>PEARL</u> First <u>B.</u> Middle <u>SNELLING</u> Last		4. DATE OF DEATH <u>SEPTEMBER 3</u> 19 <u>67</u> Month <u>3</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1888</u> 79
9. AGE (in years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Eden Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Osborn Snelling</u>		14. MOTHER'S MAIDEN NAME <u>Annie Benson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Elise Caplan</u>		Address <u>Cambridge, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> f.t.u.v. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-22</u> , 19 <u>67</u> , to <u>9-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-3</u> , 19 <u>67</u> , and that death occurred at <u>2:11</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>William R. Elliott</u>		22b. DATE SIGNED <u>9-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William R. Elliott</u>		22d. ADDRESS <u>None</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Allen Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Allen Md.</u>
24. FUNERAL DIRECTOR <u>Lewis R. Wilson</u>		25a. REC'D BY REGISTRAR <u>James Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>SEP 11 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13158

13162

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in lb <u>Adm. in Id 9/10/67</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite., give street address) <u>Peninsula General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>530 Druid Hill Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADELLA FLORENCE THOMAS</u> 4. DATE OF DEATH Month Day Year <u>September 19 19 67</u>			5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			8b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Accomac County, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Richard Thomas Marshall</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>215-50-7407-J1</u> 17. INFORMANT Address <u>Mrs. Malinda E. Ennis (Daughter)</u> <u>530 Druid Hill Ave., Salisbury, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>1991 Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>9/10/67 to 9/19/67</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at: <u>5:55 PM</u> , from the causes and on the date stated above.		
22a. SIGNATURE <u>Carrie Hearn</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Carrie Hearn</u>			22b. DATE SIGNED <u>Sept. 20 1967</u> 22d. ADDRESS <u>226 N. Division St., Salisbury, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept. 22, 1967</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Line Church Cemetery</u>			23d. LOCATION (City, town or county) <u>Whitesville, Delaware</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>			25. REC'D BY REGISTRAR <u>SEP 21 1967</u> 26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

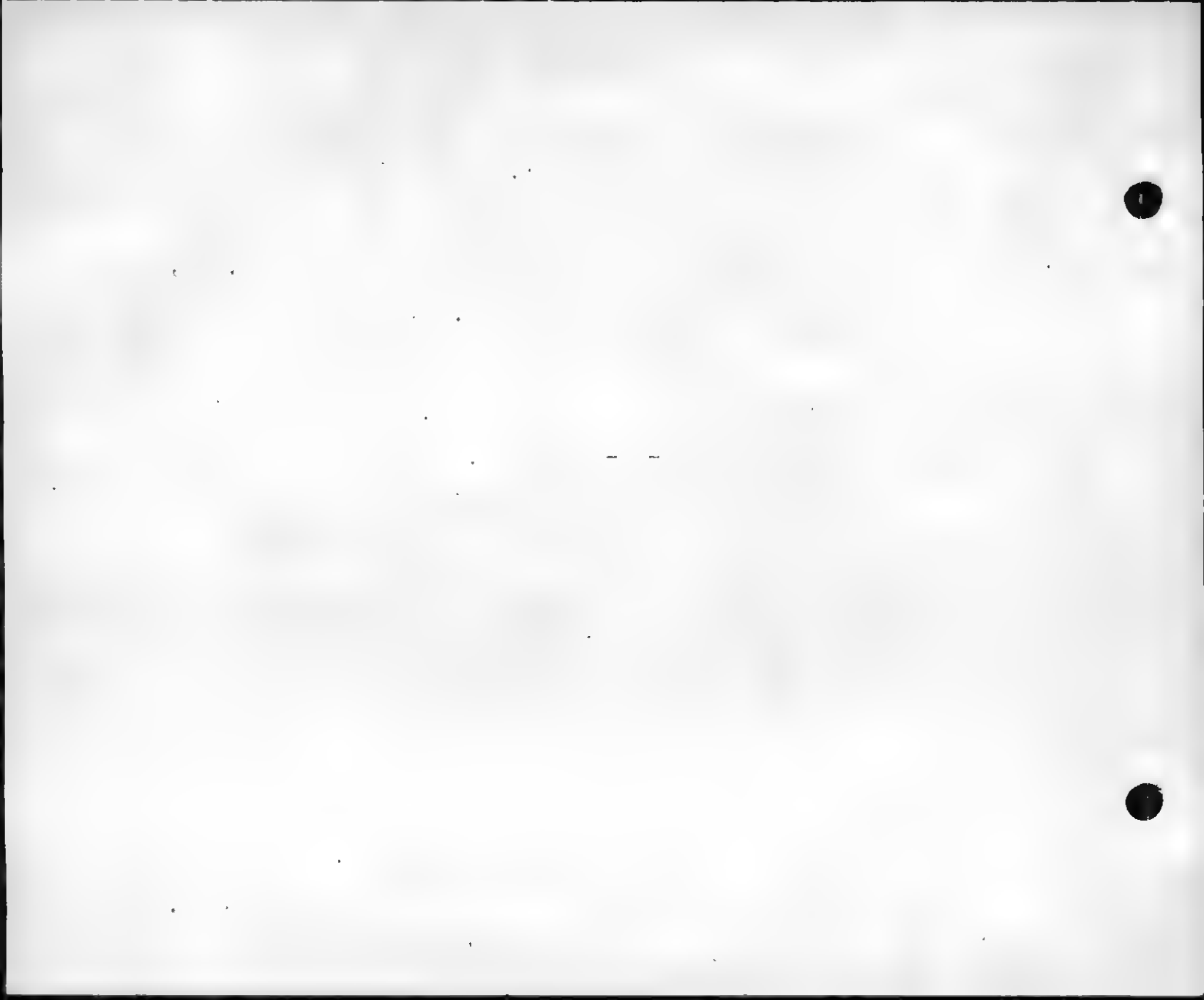
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12159											
13163											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards				c. LENGTH OF STAY IN 1b 24 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XX						d. STREET ADDRESS RFD # 1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lorenzo Handy Tubbs						4. DATE OF DEATH Month Day Year Sept. 19, 1967 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1888		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elijah Tubbs						14. MOTHER'S MAIDEN NAME Margaret Ann Truitt					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX				16. SOCIAL SECURITY NO. 214-28-7963		17. INFORMANT Address Mrs. Clara Tubbs Willards, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) accruary occlusion DUE TO (b) atherosclerosis - Hypertension DUE TO (c) 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State) Willards Maryland			
21. I certify that (I) (this hospital) attended the deceased from 9-16, 1967 , to 9-19, 1967 , that (I) (we) last saw the deceased alive on 9-19, 1967 , and that death occurred at 4:00 PM , from the causes and on the date stated above.											
22a. SIGNATURE Frank Lewis						ATTENDING M.O. PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-20-67			
22c. PHYSICIAN'S NAME (Type) Frank Lewis						22d. ADDRESS Willards Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9/12/67		23c. NAME OF CEMETERY OR CREMATORY New Hope				23d. LOCATION (City, town or county) (State) Willards, Md.			
24. FUNERAL DIRECTOR Peter Whaley, Baltimore, Md.						25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE SEP 22 1967			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13160

13164

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Virginia b COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b Virginia Beach 23455	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. - Pen.Gen. Hospital		d STREET ADDRESS 4725 Lone Willow Lane	
3. NAME OF DECEASED (Type or print) BLANEY RAM TURNER		4 DATE OF DEATH 3:10 P.M. SEPT. 12 1967	
5. SEX Male	6. CO. OR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-30-1924
9 AGE (In years last birthday) 43 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction	
11 BIRTHPLACE (State or foreign country) Lenoir Co., N. C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John Turner		14 MOTHER'S MAIDEN NAME Sadie Barfield	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 2		16 SOC. A. SECURITY NO. 240-30-0798	
17 INFORMANT Address Mrs. Lucille W. Turner, (Same as 2)		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage DUE TO Crushed Pelvis Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Truck backed over body	
20c TIME OF INJURY Month, Day, Year 2:15 P.M. 9/12/67		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Runway NASA		20f (City or town) (County) (State) Wallops Island Accomack	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer M.D.		22. DATE SIGNED Sept 13 1967	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9-16-1967	Pinelawn Park	Kinston Lenoir N. C.
24 FUNERAL DIRECTOR ADDRESS HOLLOWAY & COMPANY SALISBURY, MARYLAND		25a RECEIVED BY REGISTRAR DATE SEP 18 1967 25b. REGISTRAR'S SIGNATURE William J. Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12161

CERTIFICATE OF DEATH

14682

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 104 SPRUCE ST	
3. NAME OF DECEASED (Type or print) BESSIE MAY WARNER		4. DATE OF DEATH Month September Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1901
9. AGE (If years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME - GARMENTS	
11. BIRTHPLACE (County & State, or foreign country) TALBOT MARYLAND U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FRANK MARSHALL		14. MOTHER'S MAIDEN NAME LILLY MAY MARSH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 194-07-0354	
17. INFORMANT HACKETT WARNER		Address DELMAR, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of sigmoid colon DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0.00 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE Richard E. Hughes		22b. DATE SIGNED 9/27/67	
22c. PHYSICIAN'S NAME (Type) RICHARD E. HUGHES		22d. ADDRESS SALISBURY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF SEPT-30, 1967	23c. NAME OF CEMETERY OR CREMATORY Spring Hill	23d. LOCATION (City or Town) (County) (State) Salisbury Talbot MD
24. FUNERAL DIRECTOR William C. ...		25a. REC'D BY REGISTRAR OCT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 13162 Items #2a,b,c,d,6 & 9 info, taken from birth cert. ph
 CERTIFICATE OF DEATH 13165

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wic.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN lb —	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>		d. STREET ADDRESS —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Twin II</u> Middle <u>White</u> Last <u>White</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>1967</u>	
5 SEX <u>undetermined</u>	6 COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/27/67</u>
9 AGE (In years last birthday) yrs <u>2</u> Mo <u>36</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Wicomico</u>	
12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13 FATHER'S NAME <u>—</u>	
14 MOTHER'S MAIDEN NAME <u>Frances White</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO <u>—</u>		17 INFORMANT <u>Frances White, 1511 E. 1st St.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>unusual development</u> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State) <u>—</u>
21. I certify that (I) (this hospital) attended the deceased from <u>9/27</u> , 19 <u>67</u> to <u>3/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/27</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> PM, from causes and on the date stated above			
22a. SIGNATURE <u>Andron Fesche</u>		22b. DATE SIGNED <u>7/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>9/28/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Jesterville, Md.</u>
24 FUNERAL DIRECTOR <u>1111 E. 1st St., Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>—</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 5 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13163

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Filed #G393 10/6/67 rh

13166

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN b.d 8/27/67		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 703 Madison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle HESTER Last TOWNSEND				4. DATE OF DEATH Month September Day 4 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892 July 22, 1897	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Fitzgerald				14. MOTHER'S MAIDEN NAME Alice English			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-05-8424		17. INFORMANT Mr. Albert K. Wilkinson (Husband) 703 Madison Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UBEMIA DUE TO (b) GANGRENE FOOT (L) DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE						INTERVAL BETWEEN ONSET AND DEATH 6 WEEKS 10 days INDEF.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/27 , 1967, to 9/4 , 1967, that (I) (we) lost saw the deceased alive on 9/4 , 1967, and that death occurred at 5:30 M. from causes and on the date stated above.							
22a. SIGNATURE John M. Bloxom III				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/4/1967	
22c. PHYSICIAN'S NAME (Type) JOHN M. BLOXOM III				22d. ADDRESS Medical Center, Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 7 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13164

13167

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) First Nona Middle (none) Last Williams		4. DATE OF DEATH Month Sept. Day 27, Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1880
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Theodore Jenkins		14. MOTHER'S MAIDEN NAME Sarah Watson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Grace Jenkins		18. MAIN STREET Hebron, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia DUE TO (b) fracture lft femur DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell at home			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9-21 p.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hebron Wic. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles Judge		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PH. L. A. Insley		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 9-28-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Salisbury, Md.		23a. REC'D BY REGISTRAR SEP 23 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-30-1967	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Thomas F. Wallace		25a. REGISTRAR'S SIGNATURE Charles Judge	
Address Salisbury, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

(1)